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4235

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

64159

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN lb <b>37 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1040 Fitzallen Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>NICK</b> Middle <b>----</b> Last <b>AJDINOVICH</b>				4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 27, 1886</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>02</b> Days <b>60</b>		IF UNDER 24 HRS. Hours <b>2</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Burner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ship Yard</b>		11. BIRTHPLACE (State or foreign country) <b>Yugoslavia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Eli Ajdinovich</b>				14. MOTHER'S MAIDEN NAME <b>Marian MN: Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW I 213-07-0153</b>		17. INFORMANT Address <b>Clinical Records, VAH, Balto. 18, Md., Ft. Howard Div.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>203X MULTIPLE MYELOMA</b> IMMEDIATE CAUSE (a) <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>UNKNOWN</b>						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease. Pulmonary Emphysema. Osteoarthritis.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 14, 1960</b> to <b>April 20, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 20, 1960</b> , and that death occurred at <b>6:05 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John D. Talbert, M.D.</b>				22b. DATE SIGNED <b>4/20/60</b>		22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M.D.</b>	
22d. ADDRESS <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 25-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Fink Funeral Home</b>				25a. REC'D BY REGISTRAR <b>APR 25 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	
ADDRESS <b>426 Crain Highway, Glen Burnie Md.</b>							



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4236 CERTIFICATE OF DEATH

64160

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Howard</b>		c. LENGTH OF STAY IN 1b <b>1 Day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BERNARD</b> Middle <b>RUSSELL</b> Last <b>AQUILLA</b>		4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 13, 1900</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Allen O. Aquilla</b>		14. MOTHER'S MAIDEN NAME <b>Ellen C. Bird</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>216-09-8992</b>	
17. INFORMANT <b>18 address</b> <b>Clinical Records, VAH, Balt 9, Md. Fort Howard Div.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.0</b> DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>ARTERIOSCLEROSIS, MARKED, GENERALIZED</b> (c) <b>UNKNOWN</b> <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <b>April 3, 1960</b> to <b>April 4, 1960</b> that we last saw the deceased alive on <b>April 4, 1960</b> , and that death occurred at <b>11:10 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Caridad E. Gonzalez</b>		22b. DATE SIGNED <b>4/5/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>CARIDAD E. GONZALEZ, M.D.</b>		22d. ADDRESS <b>VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/8/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>		25a. REC'D BY REGISTRAR <b>APR 12 1960</b>	
ADDRESS <b>1808 N. Monroe St. Balto. 17 Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Caridad E. Gonzalez</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other certificate is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4213 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04161

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		c. LENGTH OF STAY IN 1b <b>8 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk (22)</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2115 Dundalk Avenue</b>				d. STREET ADDRESS <b>2115 Dundalk Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ELLEN</b> Last <b>AYERS</b>				4. DATE OF DEATH Month <b>April</b> Day <b>20th</b> , Year <b>1960</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 23, 1959</b>	
9. AGE (In years last birthday) yrs. <b>8</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b></b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Lawrence Ayers</b>				14. MOTHER'S MAIDEN NAME <b>Helen Jager</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>J.L. Ayers</b> Address <b>same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>493X</b> <b>pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b></b> DUE TO (c), stating the underlying cause last. <b></b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b></b> Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Jack C. Collins</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4/20/60</b>	
EXAMINER'S NAME (Type) <b>Jack C. Collins, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/22/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley</b>				ADDRESS <b>Dundalk 22, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE APR 25 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur J. H.</b>			

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STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME OF DECEASED JAMES EARL RAY		DATE OF DEATH 4/4/68	
AGE 35		SEX M	
RACE W		EDUCATION HS	
OCCUPATION None		MARRIAGE None	
PLACE OF BIRTH MOBILE, ALA		PLACE OF DEATH MEMPHIS, TENN	
DATE OF BIRTH 4/4/33		TIME OF DEATH 11:57 AM	
CAUSE OF DEATH FIRE		MANNER OF DEATH Suicide	
DISEASE OR INJURY None		TOXICOLOGY None	
HISTORY OF PRESENT ILLNESS None		HISTORY OF PREVIOUS ILLNESS None	
HISTORY OF DRUGS None		HISTORY OF ALCOHOL None	
HISTORY OF TUBERCULOSIS None		HISTORY OF MENTAL ILLNESS None	
HISTORY OF OTHER DISEASES None		HISTORY OF OTHER INJURIES None	
SIGNATURE OF EXAMINER J. Edgar Hoover		SIGNATURE OF WITNESS J. Edgar Hoover	
DATE OF EXAMINATION 4/4/68		DATE OF SIGNATURE 4/4/68	





Belmont

No.

Belmont

Belmont

Belmont

1700 Hall Ave

1700 Hall Ave

Thomas, Henry Norton Jr.

April 25, 1914

Wife

Wife

Rebecca Carpenter

Rebecca Carpenter

John M. Harrison

John M. Harrison

Wife

Wife

John M. Harrison 325 Fifth Ave. New York N.Y.

John M. Harrison

John M. Harrison

John M. Harrison 325 Fifth Ave.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**4237 CERTIFICATE OF DEATH**

**05389**

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN lb <b>26 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
				d. STREET ADDRESS <b>1103 WEST SARATOGA STREET</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>BENJAMIN</b>		First <b>H</b> Middle <b>BATES</b> Last		4. DATE OF DEATH <b>APRIL</b>		Day <b>30</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 30, 1893</b>		9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEONARD BATES</b>				14. MOTHER'S MAIDEN NAME <b>SUSAN GAINES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>YES WW-1</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>CLIN REC VAH BALTO MD FT HOWARD DIVISION</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PROSTATIC CARCINOMA WITH METASTASIS</b> <b>177X</b> <b>256-15</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>RECTAL CARCINOMA</b> (c) <b>DUE TO</b> INTERVAL BETWEEN ONSET AND DEATH <b>? 3 MONTHS</b> <b>? 3 MONTHS</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ANEMIA; CYSTITIS.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 4, 1960</b> to <b>April 30, 1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 30, 1960</b> , and that death occurred <b>12:30am</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Daniel A. Nieves</i>				22b. DATE SIGNED <b>4-30-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>DANIEL A NIEVES</b>				22d. ADDRESS <b>M.D. VAH Baltimore Md - Ft Howard Division</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-4-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Charles G Cooper</i> ADDRESS <b>Charles G Cooper Funeral Home</b>				25a. REC'D BY REGISTRAR <b>MAY 6 '60</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	
512 N Carrollton Ave Baltimore 23 Md							

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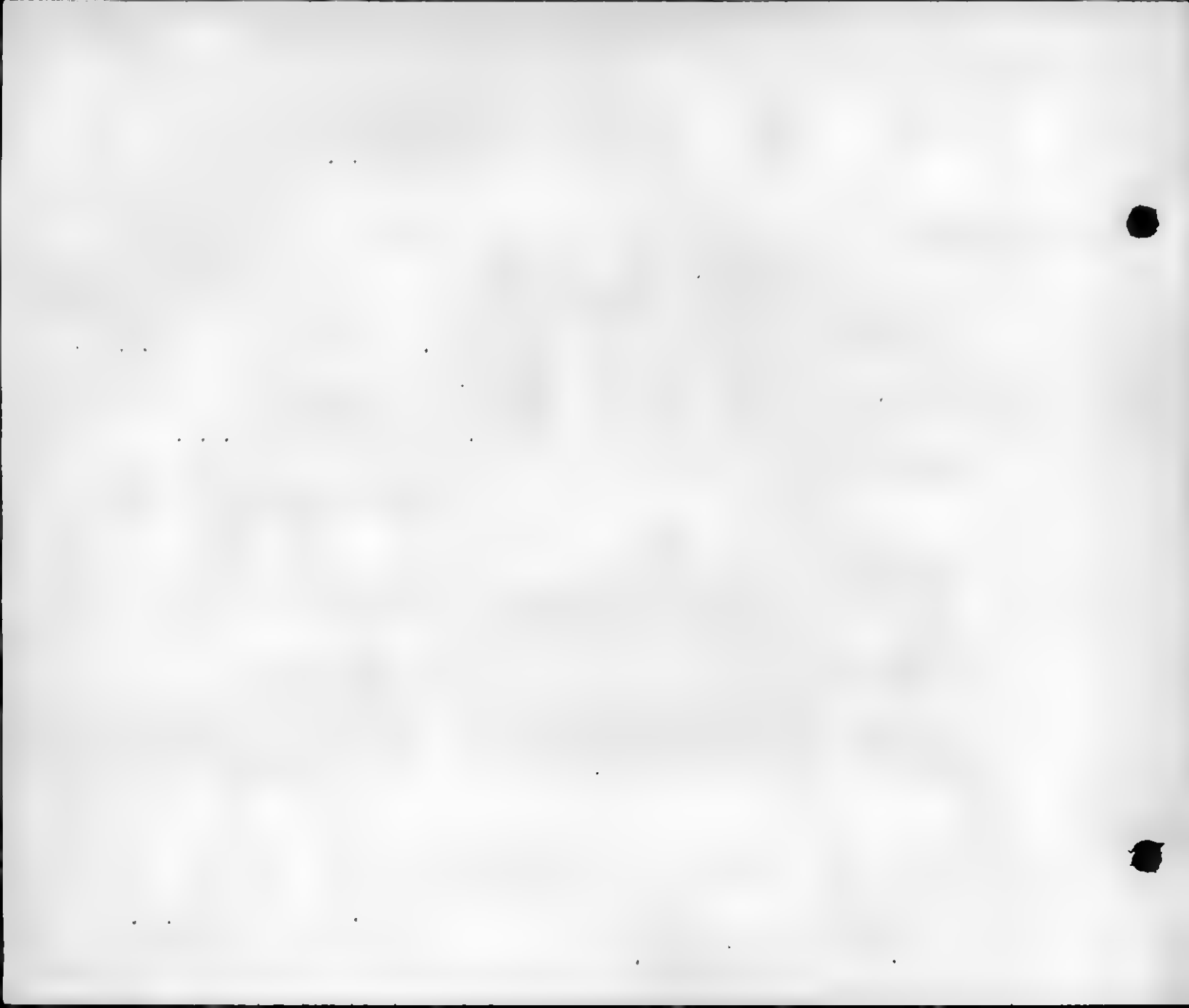
## 4231 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN 1b <b>In Transit</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Oshorn Lane</b>		d. STREET ADDRESS <b>Taneytown R.D.1</b>	
3. NAME OF DECEASED (Type or print) First <b>Francenia</b> Middle <b>Edna</b> Last <b>Becker</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/9/1919</b>
9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months <b>40</b> Days <b>17</b>	IF UNDER 24 HRS. Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Robert J. Sites</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Belle Gardner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Oscar L. Becker, Taneytown, Md. R.D.1</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Skull - Crushed chest</b> DUE TO <b>apoplexy. traumatic amputation of L. arm</b> DUE TO <b>Train - Car accident.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>- none</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Car struck by train at crossing</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>7</b> a. m. <b>Apr 17 1960</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street - Rail Rd.</b>		20f. (City or town) <b>Reisterstown</b> (County) <b>Walt.</b> (State) <b>7th</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>D. D. Caples</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>D. D. CAPLES</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 21/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>York Road Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Nr. Hanover, York, Co. Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>		ADDRESS <b>Littlestown, Pa.</b>	
24a. REC'D BY REGISTRAR <b>APR 20 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



Reg. Dist. No.

VS. A15ME(S)  
SM 9/55

1. PLACE OF DEATH a. COUNTY <u>TOWSON BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b <u>55 TOWNSON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <u>14 LENNOX AVE</u>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>WESLEY</u> Middle <u>BLAKE</u> Last		4. DATE OF DEATH Month <u>APRIL</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 29, 1868</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Messenger</u>		12. BIRTHPLACE (State or foreign country) <u>Eastern Shore, Md.</u>	
13. FATHER'S NAME <u>Percy Blake</u>		14. MOTHER'S MAIDEN NAME <u>Liza</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. <u>MAUDE</u> Address <u>Maudie Hopkins</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/7/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest</u>		22d. LOCATION (City, town, or county) (State) <u>Towson Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl Gilmore</u>		ADDRESS <u>519 Mosher St</u>	
24a. REC'D. BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	
DATE <u>APR 11 '60</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose it in a separate envelope and forward it to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4239 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 44165

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN lb <u>6mth11dys</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>QUEEN ANNE</u>	
f. STREET ADDRESS <u>none</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Adolphus</u> Last <u>Bland</u>		4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 8, 1883</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>212-16-1286</u>	
17. INFORMANT <u>Records</u>		Address <u>SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>936.7</u> DUE TO <u>Pneumonia, Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>fracture left hip accident</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>On 2-10-60 reduction and Steinmann pinning was performed</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>On 1-24-60 patient was found with laceration over the left eye and frac. left hip; cause unknown</u>	
20c. TIME OF INJURY Month, Day, Year <u>7:45 xx 1-24-60</u>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	
20e. (City or town) <u>Catonsville 28, Md.</u>		(County) <u>  </u> (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>George M. Kieffer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>April 8, 60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/11/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>		22d. LOCATION (City, town, or county) <u>Church Hill Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		24a. REC'D BY REGISTRAR <u>APR 13 '60</u>	
ADDRESS <u>Church Hill Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

731X

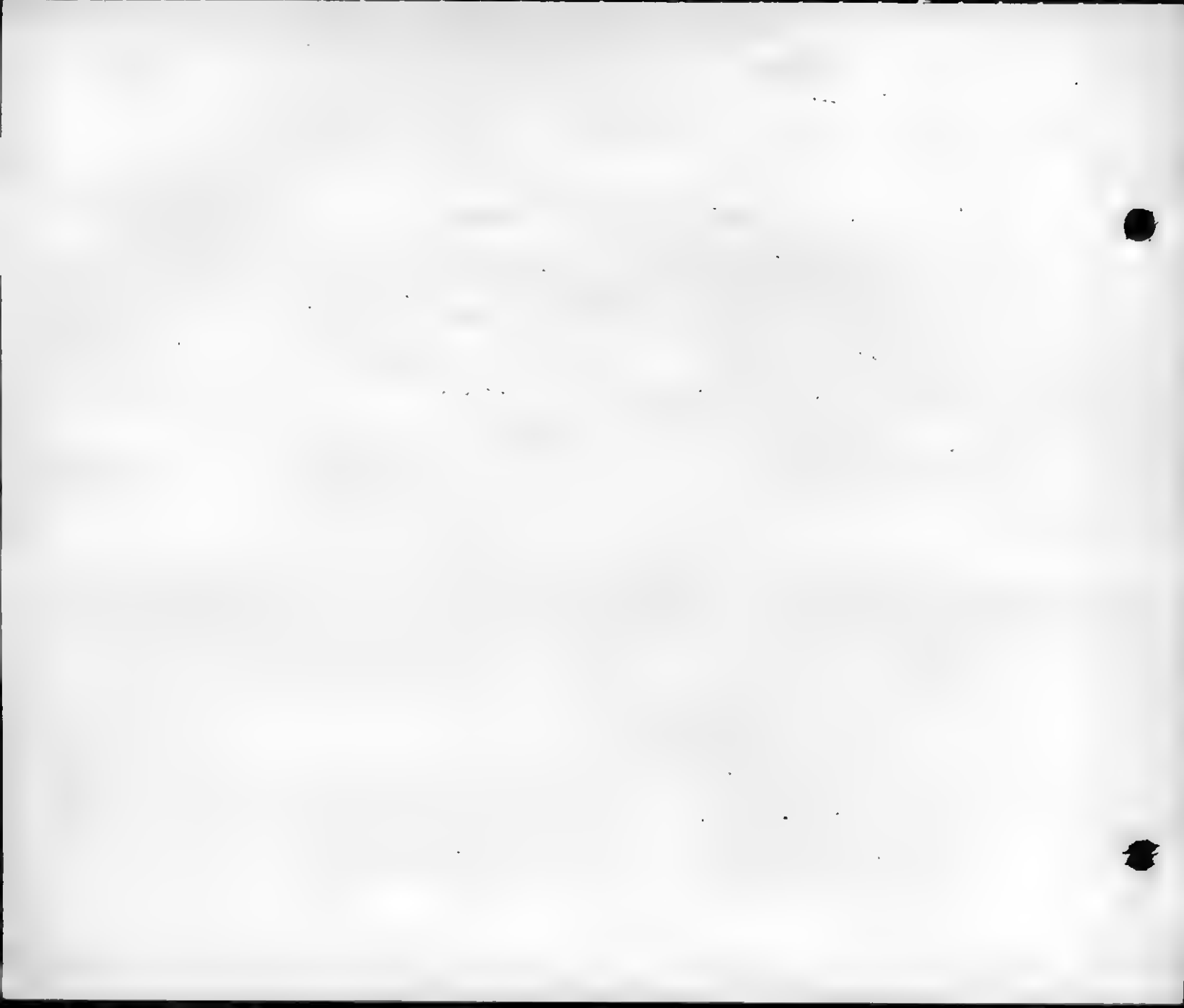


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4240  
CERTIFICATE OF DEATH  
64166

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. LENGTH OF STAY IN 1b <u>1</u>		3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		4. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines</u>				e. STREET ADDRESS <u>Catonville High School</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William L.</u> Middle <u>Boggs</u> Last <u>Boggs</u>				4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/26/94</u>	9. AGE (In years last birthday) <u>66</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher Balt. Co. Schools</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>S. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown to informant</u>				14. MOTHER'S MAIDEN NAME <u>Unknown to informant</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes WWI NAVY</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Howard Griffin</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ch. Hypertensive Cardio-Vascular Disease</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>13 da.</u> <u>33y</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-3-</u> 19 <u>57</u> to <u>4-18-</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>4-16-</u> 19 <u>60</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Wilmer K. Gallagher</u>				22b. DATE SIGNED <u>4/21/60</u>		22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher M.D.</u>	
22d. ADDRESS <u>6209 Frederick Ave. Balt. 28, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/22/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Smith &amp; Son Co. 28</u>				25a. REC'D BY REGISTRAR DATE <u>APR 22 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur J. Kline</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

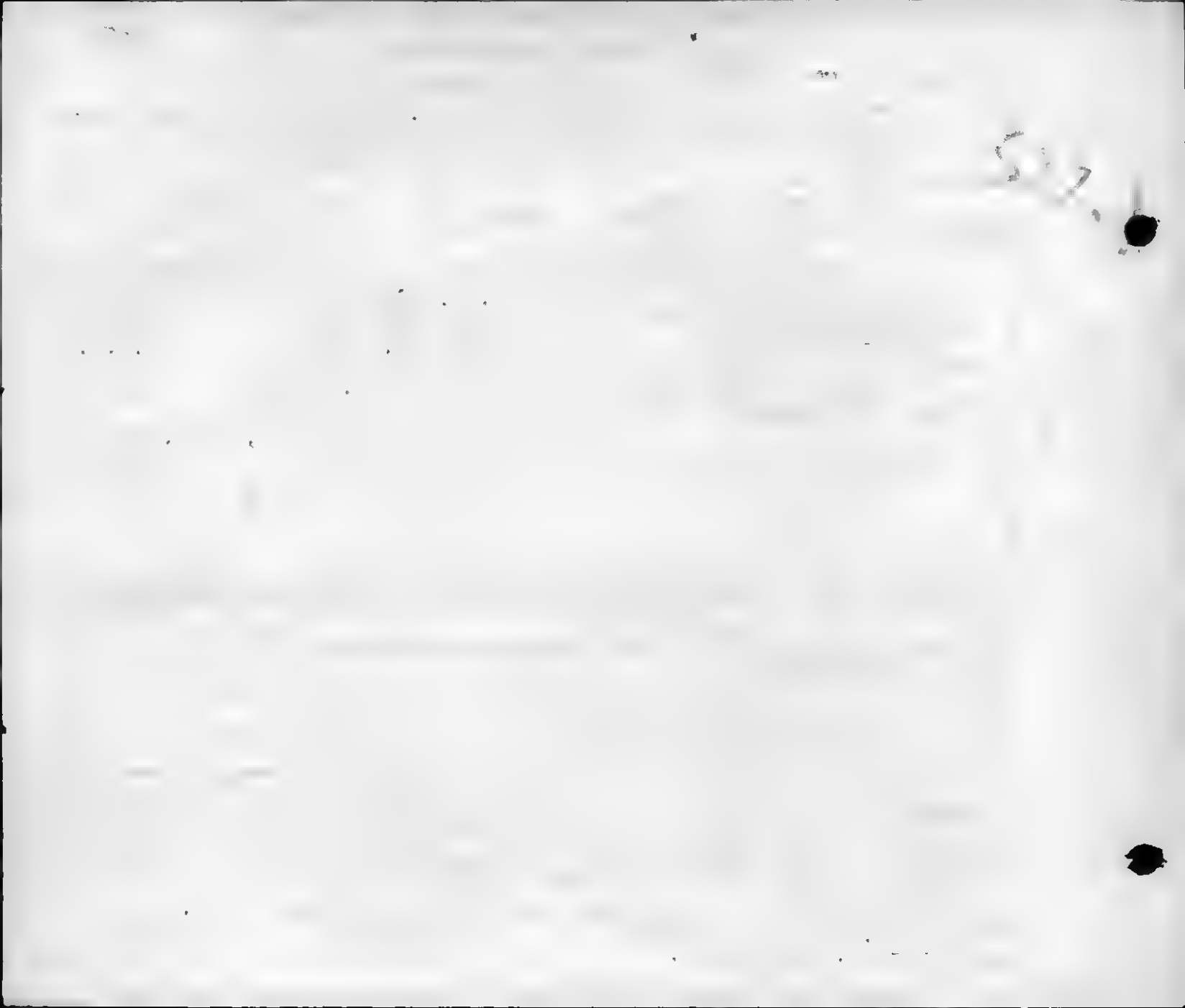
## 4214 CERTIFICATE OF DEATH

Reg. Dist. No.

64167

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1726 Langport Avenue</b>		d. STREET ADDRESS <b>1726 Langport Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>SYLVAN</b> Last <b>BOHLE</b>		4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 23, 1892</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none - retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>York, Pa.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Frank Anthony Bohle</b>	
14. MOTHER'S MAIDEN NAME <b>Katherine M. Huppman</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Margaret Wilhelm Bohle, wife, above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> 501X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Asthmatic bronchitis - pulm. emphysema &amp; fibrosis</b> (c) <b>Emphysema &amp; fibrosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>25 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>Mar. 1959</b> to <b>April 1960</b> that I last saw the deceased alive on <b>12 April 1960</b> and that death occurred at <b>11:20 P.M.</b> from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>B. W. Sollard, M.D.</b>		ADDRESS (Street, city or town, state) <b>2900 Dunbar Rd</b> DATE SIGNED <b>4-16-60</b>	
PHYSICIAN'S NAME (Type) <b>B. W. Sollard, M.D.</b>		22a. REC'D BY REGISTRAR DATE <b>APR 20 '60</b>	
22b. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22c. DATE THEREOF <b>4/19/60</b>	
22d. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22e. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Schimunek</b>		ADDRESS <b>2601-3-5 E. Madison St.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



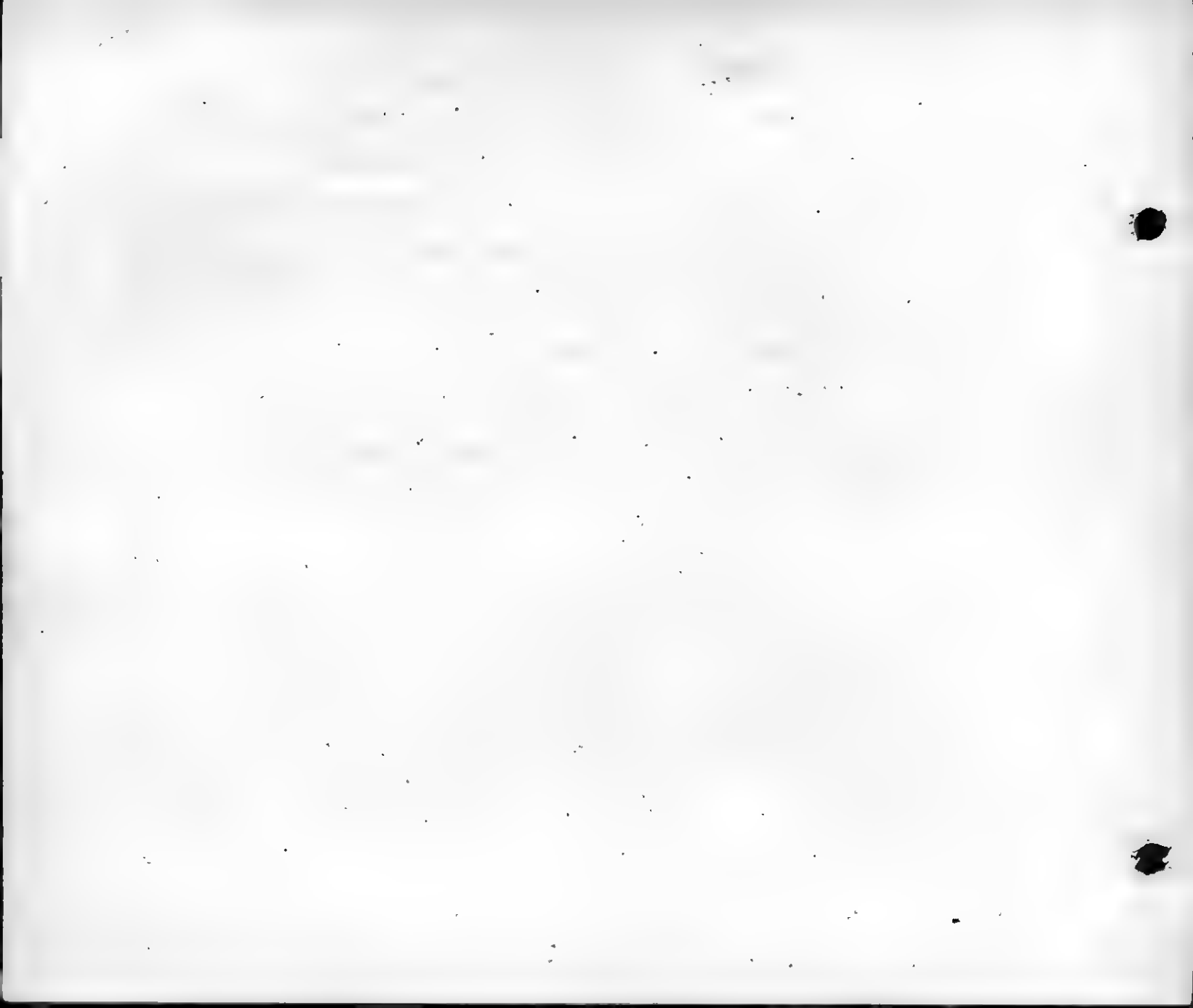
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EDGEWATER</b>	c LENGTH OF STAY IN 1b	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EDGEWATER</b>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2149 GRAYTHORN RD.</b>		d. STREET ADDRESS <b>2149 GRAYTHORN RD.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>JEAN</b> First <b>C.</b> Middle <b>BOLCH.</b> Last		4. DATE OF DEATH Month <b>APRIL</b> Day <b>16</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>MAY 27, 1916</b>
9. AGE (In years last birthday) yrs. <b>43</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SCHOOL TEACHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL TEACHER</b>	11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>CLYDE CHADDOCK.</b>		14. MOTHER'S MAIDEN NAME <b>HELEN SCOTHERN.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>232-20-908.</b>	
INFORMANT <b>MRS KENNETH ARNOLD</b>		Address <b>2151 GRAYTHORN RD.</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> <b>172X</b> DUE TO <b>Malignancy of Spine</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Carcinoma of Fundus of Uterus</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>14 months</b> <b>7 months</b> <b>18 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October</b> , 19 <b>58</b> , to <b>Apr 16</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Apr 16</b> , 19 <b>60</b> , and that death occurred at <b>7:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Morris A. Jacobs</b> M.D.		ADDRESS (Street, city or town, state) <b>1010 NORTH Point Road</b>	
PHYSICIAN'S NAME (Type) <b>MORRIS A. Jacobs</b>		DATE SIGNED <b>4/16/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>APRIL 19, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH</b>		22d. LOCATION (City, town, or county) (State) <b>FULLETON MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sassala Funeral Home</b>		ADDRESS <b>7401 Belair Rd. #6/M</b>	
24a. REC'D BY REGISTRAR <b>APR 21 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please receive carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

4169

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>404 E Randall St Baltimore</u>	
3. NAME OF DECEASED (Type or print) <u>JOSEPHINE</u> First Middle Last		4. DATE OF DEATH Month <u>4</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/11/1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>Housewife</u>		<u>Baltimore</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Baltimore</u>		<u>U. S. A</u>	
13. FATHER'S NAME <u>Geo. Nash</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Kober</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
<input type="checkbox"/>		<input type="checkbox"/>	
17. INFORMANT		Address	
<u>George E. Urban</u>		<u>805 Fredrick Ave 28</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Embolism</u> DUE TO <u>Cardio-Vascular Renal Disease</u> DUE TO <u>Cardiac Decompensation</u> DUE TO <u>17 yrs.?</u> DUE TO <u>4 months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1:21</u> , 19 <u>58</u> , to <u>4:10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/8</u> , 19 <u>60</u> , and that death occurred at <u>8:5</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>805 Fredrick Ave 28</u> DATE SIGNED <u>4/10/60</u>	
ACTUAL SIGNATURE <u>George E. Urban</u> M.D.		DATE SIGNED <u>4/10/60</u>	
PHYSICIAN'S NAME (Type) <u>George E. Urban</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/13/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Fahy</u> Address <u>1318 Leggett</u>		24a. REC'D BY REGISTRAR <u>APR 14 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fraw</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

434.4

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Filed 4/20/60 iwk

4243

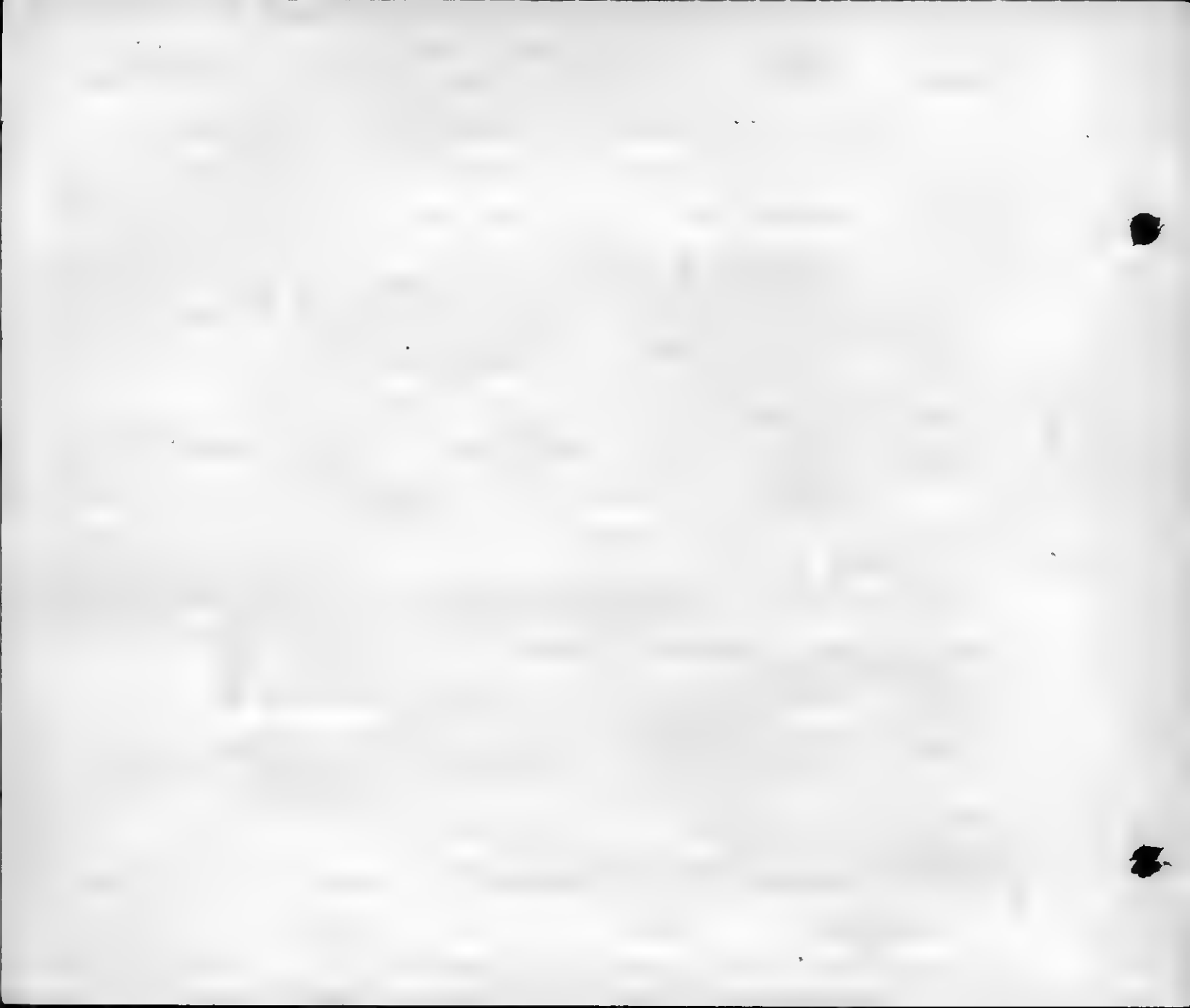
## CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH a. COUNTY <u>Balto 19</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>as in</u> b. COUNTY <u># 1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharrows Pt</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2405 RUTH AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EMMA J.</u> Middle <u>BROWN</u> Last <u>BROWN</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>FEM.</u>		6. COLOR OR RACE <u>COL.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 24 1902</u>	
9. AGE (In years last birthday) <u>57</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lucas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mary Newby - as in # 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>Hypertensive - arteriosclerotic C.V. disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>7 yrs</u> (c) <u>10 days</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 1, 1960</u> to <u>April 20, 1960</u> , that I last saw the deceased alive on <u>April 19, 1960</u> , and that death occurred at <u>S.A.L.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis N. Tollin</u> M.D.				ADDRESS (Street) city or town, state) DATE SIGNED <u>6908 N. VONTRD. 4/20/60</u>			
PHYSICIAN'S NAME (Type) <u>LOUIS N. TOLLIN</u>				BALTIMORE-19- MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-23-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. CALVARY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barbara L. Law - 802 Madison Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kunk</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

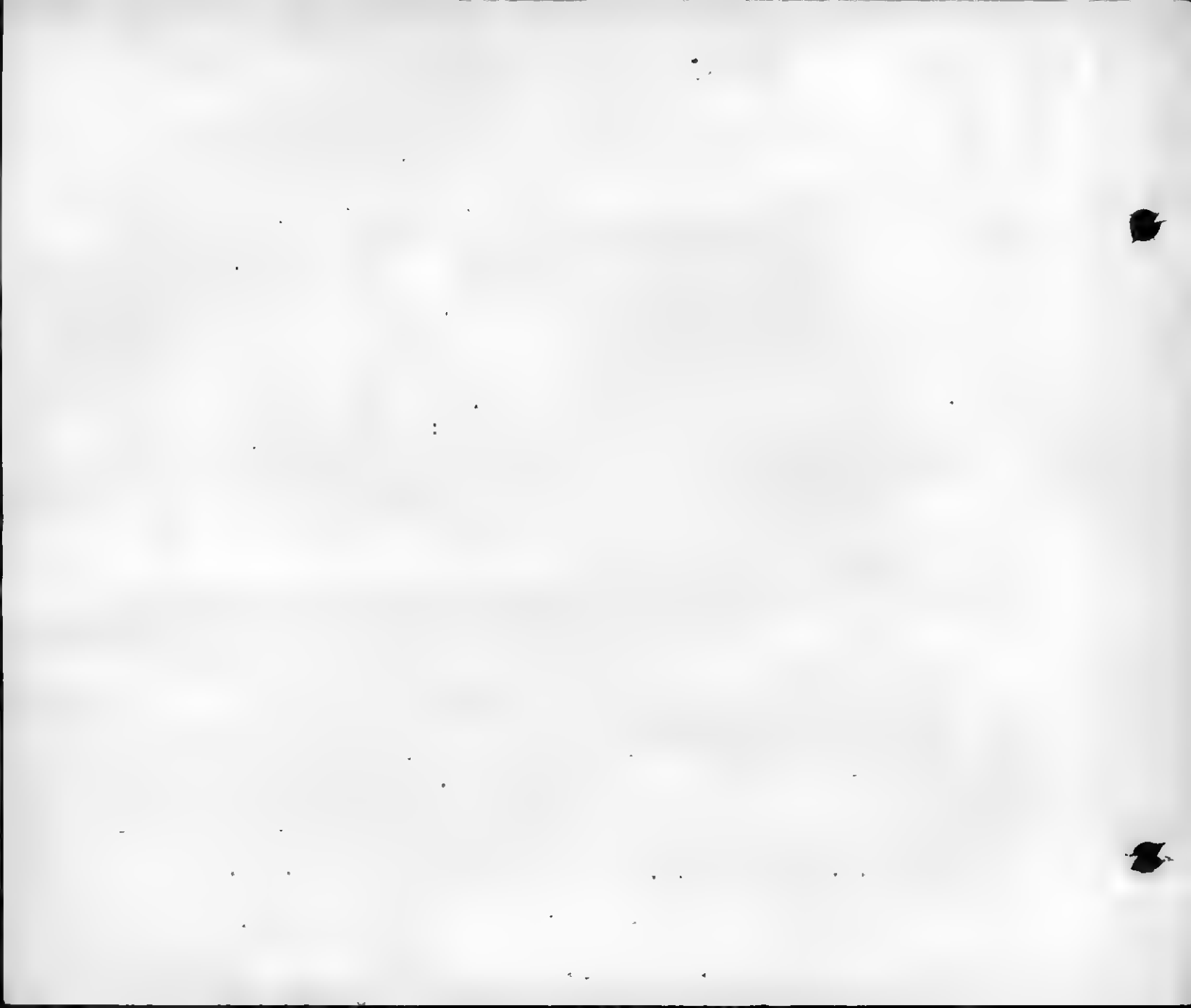
4244

## CERTIFICATE OF DEATH

64172  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Douglas Memorial Home</b>		d. STREET ADDRESS <b>5921 Frederick Road</b>	
3. NAME OF DECEASED (Type or print) <b>JOSEPH NMI BROWN</b>		4. DATE OF DEATH Month <b>Apr.</b> Day <b>23</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 6, 1881</b>
9. AGE (In years last birthday) <b>78</b> yrs		10. IF UNDER 1 YEAR: Months <b>7</b> Days <b>19</b> Hours <b>60</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unk.</b>		14. MOTHER'S MAIDEN NAME <b>Unk.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMATION <b>Records: Douglas Memorial Home</b> <b>5921 Frederick Road</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>7</b> Days (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive-Arterio-sclerosis</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-16-60</b> , 19 <b>60</b> , to <b>4-23-60</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4-23-60</b> , 19 <b>60</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>57 Winters Lane -28</b> DATE SIGNED <b>4-23-60</b>			
ACTUAL SIGNATURE <b>C. F. Maloney M.D.</b>		PHYSICIAN'S NAME (Type) <b>C. F. Maloney, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/26/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>		22d. LOCATION (City, town, or county) (State) <b>Balto, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Holland Funeral Home</b> <b>1631 Druid Hill Ave.</b>		24a. REC'D BY REGISTRAR <b>APR 27 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

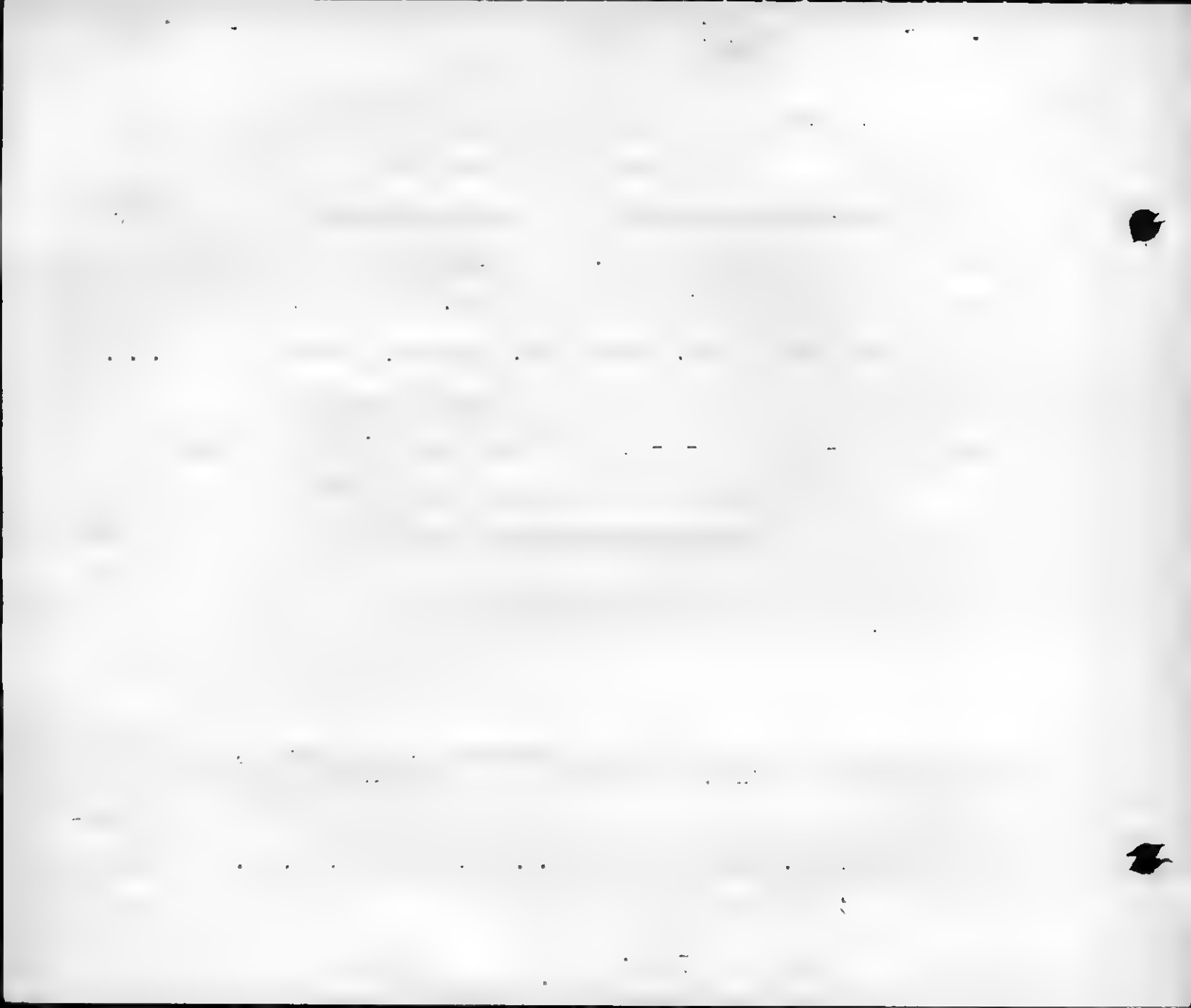
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 48 hours after death.



TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4245 CERTIFICATE OF DEATH 64173

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>34 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>2208 LYNBROOK AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WEBB</b> Middle <b>F.</b> Last <b>BROWN</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>1</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>COLORED</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 16, 1889</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		10. KIND OF BUSINESS OR INDUSTRY <b>DEPT. INTERNAL REV.</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN BROWN</b>				14. MOTHER'S MAIDEN NAME <b>ORRICK WILLIAMS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW-1</b>				16. SOCIAL SECURITY NO. <b>216-18-0932</b>		17. INFORMANT <b>CLIN REC VAH BALTO MD FT HOWARD DIVISION</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY INFARCTION OF THE RIGHT LUNG</b> <b>464x</b> DUE TO (b) <b>THROMBOPHLEBITIS OF LEFT FEMORAL VEIN</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>AORTITIS, CHRONIC</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b> <b>1 WEEK</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>February 27, 1960</b> to <b>April 1, 1960</b> that <b>he</b> (we) last saw the deceased alive on <b>April 1, 1960</b> , and that death occurred at <b>4:55 pm</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Clyde B. Cope</b>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4-2-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>CLYDE B. COPE</b>				22d. ADDRESS <b>M.D. VAH, Baltimore, Md.-Ft. Howard Division</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-6-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>				ADDRESS <b>1808-10 N. Monroe St</b>		25a. REC'D BY REG STRAR DATE <b>APR 12 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Curtis S. Frank</b>	
Baltimore 17, Md.							





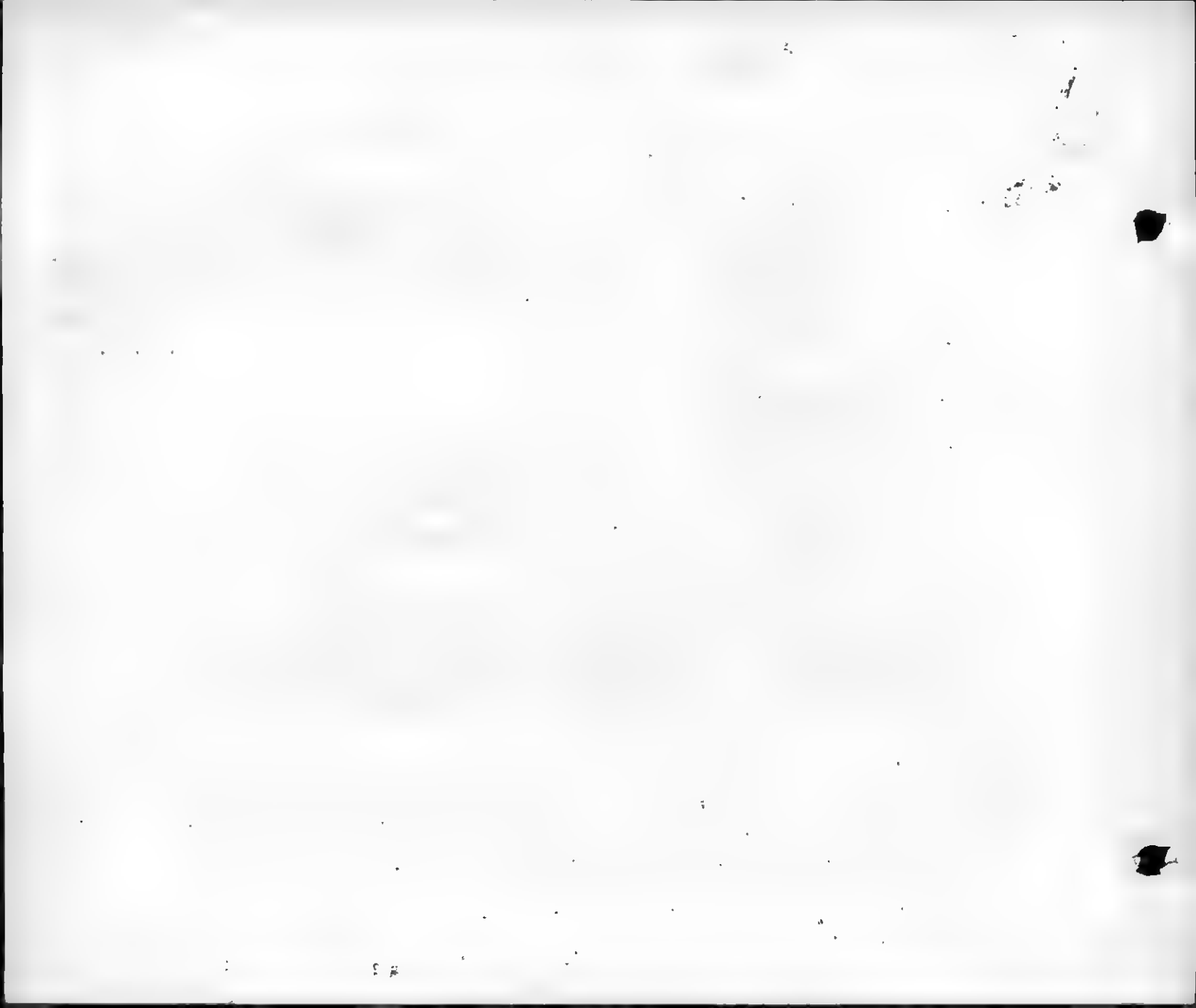
04174

## 4246 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>11yr9mth13dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>1721 Hollins Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Martina</b> Middle <b>A.</b> Last <b>Bryan</b>				4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>1960</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 30, 1874</b>	
9. AGE (In years last birthday) <b>86</b> yrs		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>hospital worker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Alfred Thomas Bryan</b>				14. MOTHER'S MAIDEN NAME <b>Emily Higgins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unkn wn</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
17. ADDRESS <b></b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b></b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that I attended the deceased from <b>March 9, 1960</b> , to <b>April 25, 1960</b> , that I last saw the deceased alive on <b>April 25, 1960</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>4-25-60</b>							
ACTUAL SIGNATURE <b>Bruno Radauskas</b>		M.D. <b>SPRING GROVE STATE HOSPITAL</b>					
PHYSICIAN'S NAME (Type) <b>BRUNO RADAUSKAS</b>		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>28 April 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter C. Walters</b>		ADDRESS <b>Pat &amp; Spence Sts</b>		24a. REC'D BY REGISTRAR DATE <b>APR 27 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

VS A15 (4)  
15M 9/58



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**4247** **CERTIFICATE OF DEATH** **04175**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>131 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>542 Parksley Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANCIS E. BURTON</b>				4. DATE OF DEATH Month Day Year <b>APRIL 9 19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/19/13</b>	
9. AGE (In years last birthday) <b>46</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stationary Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Brewery</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Robert R. Burton</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>218-05-0051</b>			
(If yes, give war or dates of service) <b>WW II</b>				17. INFORMANT Address <b>Clin. Rec. VAH, Balto. Md. Ft. Howard Division</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LAENNEC'S CIRRHOSIS WITH JAUNDICE AND ASCITES</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <b>6 Months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 30 1959</b> to <b>April 9 1960</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>April 9 1960</b> , and that death occurred at <b>7:18 AM</b> on the causes and on the date stated above.							
22a. SIGNATURE <i>Charles Allen M.D.</i>				22b. DATE SIGNED <b>4/9/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>CHARLES ALLEN, M.D.</b>				22d. ADDRESS <b>VAH, BALTO., MD. FORT HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 13/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir.</b>				25a. REC'D BY REGISTRAR <b>DATE APR 12 '60</b>		25b. REGISTRAR'S SIGNATURE <i>Charles S. H...</i>	
ADDRESS <b>4101 Edmondson Avenue Baltimore, Maryland</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

582.1

may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**4248 CERTIFICATE OF DEATH**

64176

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>				c. LENGTH OF STAY IN 1b <b>4 MONTHS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASCNIC HOME</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CLARENCE H BUTTON</b>				4. DATE OF DEATH <b>APRIL 3 1960</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 18, 1881</b>	9. AGE (In years last birthday) <b>79</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATCH MAN</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>WILLIAM H. BUTTON</b>				14. MOTHER'S MAIDEN NAME <b>ANGELINE MCCANN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Frank L. Smith Jr.</b>		Address <b>Cockeysville Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Arterio Sclerotic Cardio</b> DUE TO <b>Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2.1</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>12-9</b> , 19 <b>57</b> , to <b>4-1</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>4-1</b> , 19 <b>60</b> , and that death occurred at <b>1.30 P.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Walter T. Kees</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/3/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>				22d. ADDRESS <b>COCKEYSVILLE MD</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-6-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION (City, town, or county) (State) <b>Taylor Ave &amp; Dalesford Road</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc.</b>				ADDRESS <b>1217 St. Paul Street</b>		25a. REC'D BY REGISTRAR <b>APR 6 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>			



## CERTIFICATE OF DEATH

Reg. Dist. No. 64177 32

4249

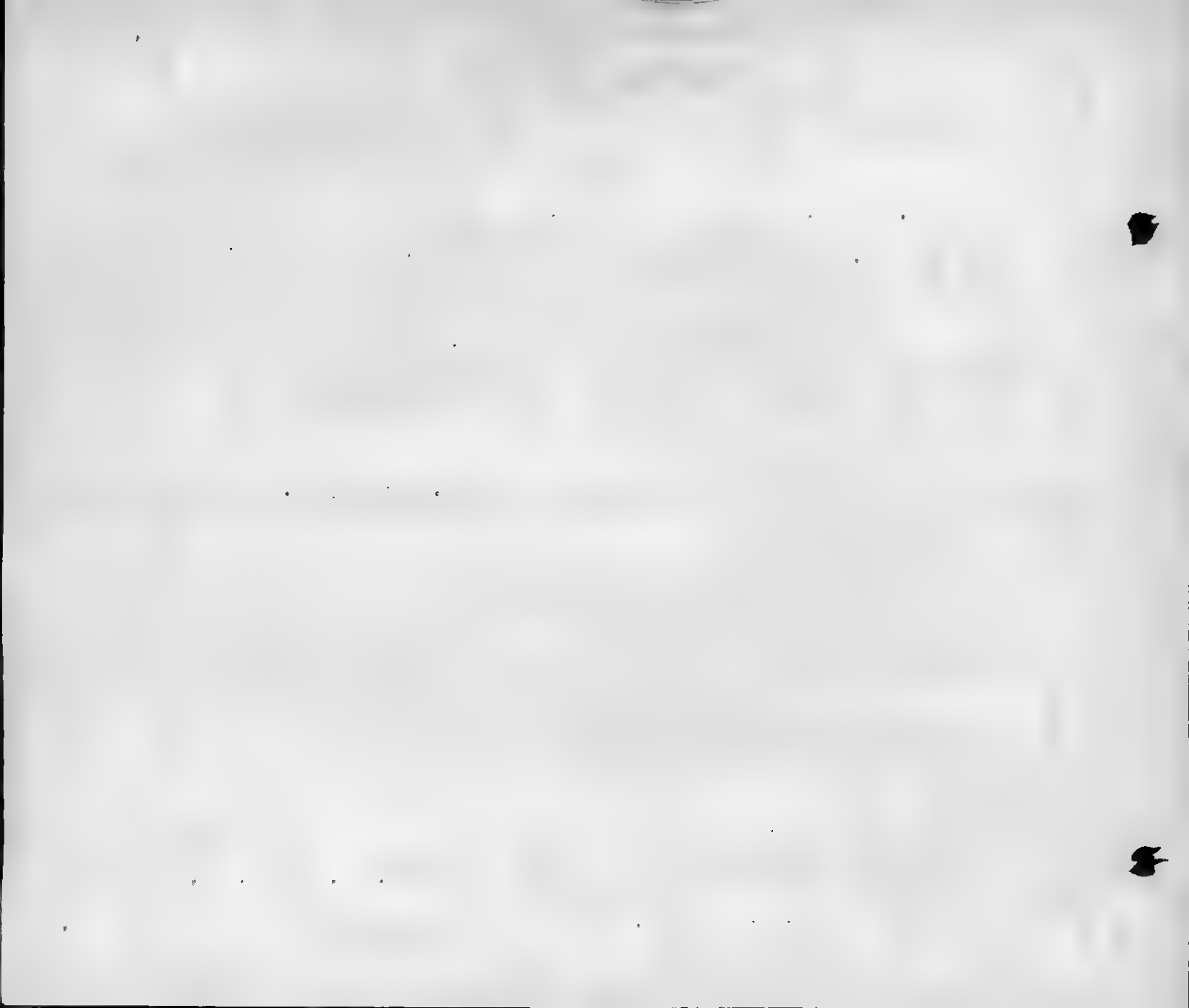
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore County</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Mt. Wilson, Maryland</u>		<u>40 days</u>		TOWN <u>Frostburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>191 E Main St.</u>			
3. NAME OF DECEASED (Type or Print) <u>Patrick Francis Cavanaugh</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>4 16 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>4/1/1899</u>	9. AGE last birthday <u>61</u> yrs.		IF UNDER 1 YEAR (Month) (Day) (Year) <u>16 19 60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tire builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly-Sp Tire Co</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Patrick F. Cavanaugh</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth T. Atkinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-07-0030</u>		17. INFORMANT & ADDRESS <u>Hosp. Records, Mt. Wilson State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>163x Carcinoma of Lung</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 month</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/7</u> , 19 <u>60</u> , to <u>4/16</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/16</u> , 19 <u>60</u> , and that death occurred at <u>9:35 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William Newcomer</u>				ADDRESS (Street, city, town, state) <u>M.D. Superintendent, Mt. Wilson, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-19-60</u>		NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hafes Funeral Home</u>		ADDRESS <u>Brown &amp; Montclair Frostburg Md</u>	
DATE <u>APR 20 '60</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64178

Reg. Dist. No.

4215

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTO.</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PATAPSCO RIVER NR. HARBOR FIELD</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5 DUNDALK (22)</u> d. STREET ADDRESS <u>320 YORK WAY</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>EUGENE (NM) CLEMONS</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>4/9/1960</u> 19							
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>OCT 28, 1946</u>		<b>9. AGE</b> (In years last birthday) <u>13</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>—</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>CURTIS CLEMONS</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>VERSIE HOWERTON CLEMONS</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> Address <u>CURTIS CLEMONS - FATHER - 2 ABOVE</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>DROWNING</u> <u>850X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from home-made rope while fishing.</u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>4-9-60</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>PATAPSCO RIVER</u>		<b>20f. (City or town)</b> <u>DUNDALK</u> (County) <u>BALTO.</u> (State) <u>MD</u>			
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <u>M. B. Davis</u>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <u>4/11/60.</u>			
<b>EXAMINER'S NAME (Type)</b> <u>Melvin B. Davis, M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>				<b>22b. DATE THEREOF</b> <u>4/12/1960</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>BALTO. NATIONAL</u>				<b>22d. LOCATION (City, town, or county)</b> <u>BALTO. MD.</u> (State)	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Walter J. Bradley, Dundalk, Md.</u>						<b>24a. REC'D BY REGISTRAR</b> DATE <u>APR 13 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

929 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4250

## CERTIFICATE OF DEATH

04179  
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WOODLAWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - PARKTON, MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOX #208 DOGWOOD RD.</u>		d. STREET ADDRESS <u>BOX #208 DOGWOOD ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>JOA</u> Middle <u>FLORENCE</u> Last <u>COMPTON</u>		4. DATE OF DEATH Month <u>4</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/13/79</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM BUTLER</u>		14. MOTHER'S MAIDEN NAME <u>MARY HAY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>IDA G BAUBLITZ - DAUGHTER</u>		Address <u>6805 CHIPPENADE BALTO.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DEGENERATIVE HEART DISEASE</u> DUE TO (c) <u>10 YEARS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>ONE WEEK</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/12</u> , 19 <u>53</u> , to <u>4/10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/9</u> , 19 <u>60</u> , and that death occurred at <u>4:08</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edwin L Pierpont</u> M.D.		ADDRESS (Street, city or town, state) <u>2204 LIBERTY RD, BALTO, MD</u>	
PHYSICIAN'S NAME (Type) <u>EDWIN L PIERPONT, M.D.</u>		DATE SIGNED <u>4/10/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>APRIL 13, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MOUNT OLIVE</u>	22d. LOCATION (City, town, or county) (State) <u>RANDALLSTOWN, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gaston Sowa</u> ADDRESS <u>CATONSVILLE, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 13 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Chas. B. K...</u>	

4.34.4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

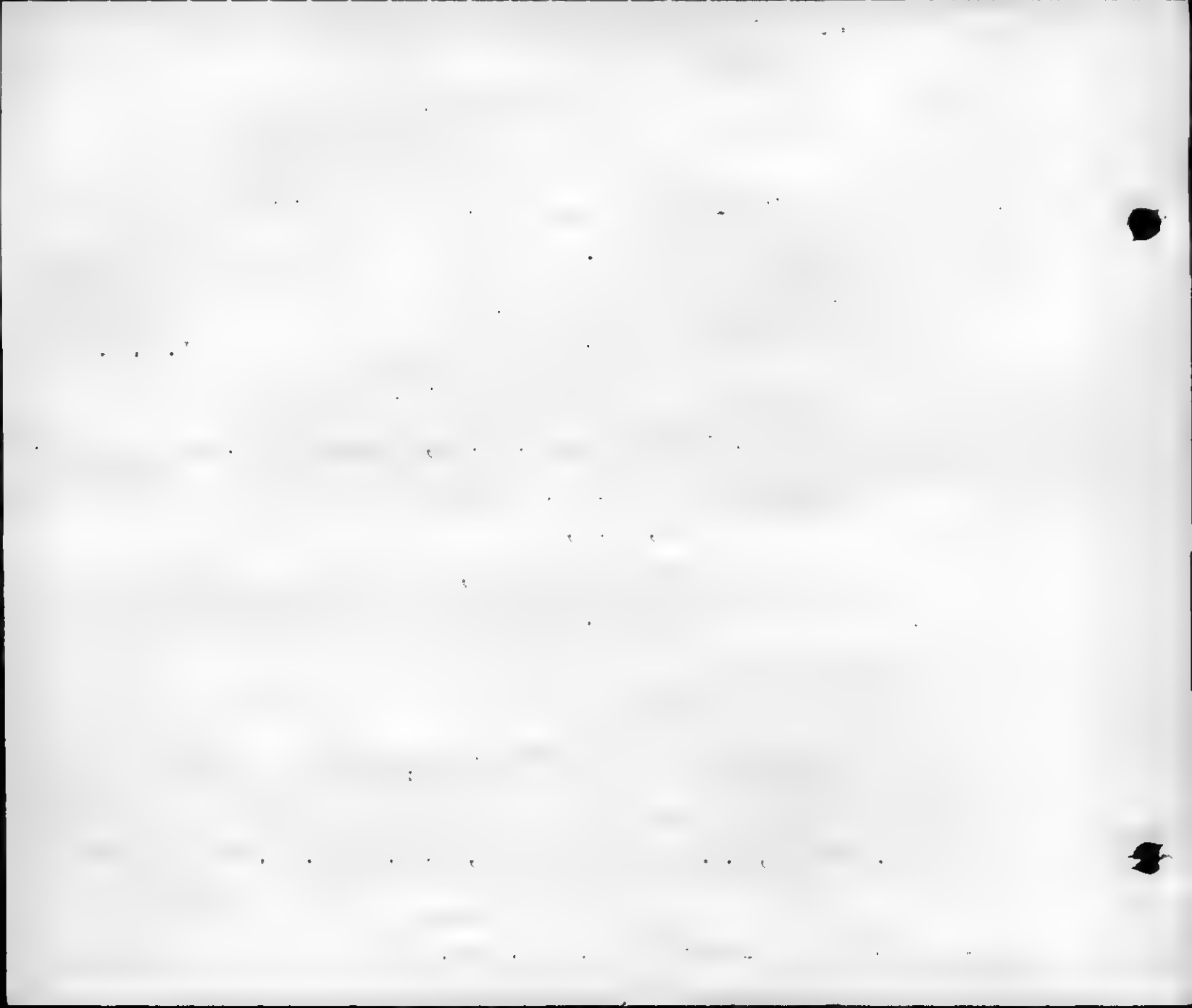
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4251

CERTIFICATE OF DEATH

64180

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>96 Days</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> (19)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HARRY</b> First <b>M.</b> Middle <b>CONRAD</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>1960</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 31, 1895</b>	9. AGE (In years last birthday) <b>65</b> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brick Layer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Company</b>		11. BIRTHPLACE (State or foreign country) <b>Chapel, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Gustav Conrad</b>				14. MOTHER'S MAIDEN NAME <b>Susie Kisinger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 213-09-4172</b>		17. INFORMANT <b>Clin. Rec. VAH, Baltimore 18, Md. Fort Howard Division</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, LEFT</b> <del>X</del> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>EMPHYEMA, RIGHT, OLD</b> <del>X</del> (c) <b>PULMONARY HEART DISEASE, OLD</b>							INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Surgical absence, right lung, old. Metastatic Carcinoma, bone L4&amp;L5, Old</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 1, 1960</b> to <b>April 15, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 15, 1960</b> , and that death occurred at <b>2:10 AM</b> at the causes and on the date stated above.							
22a. SIGNATURE <i>Caridad E. Gonzalez</i>				22b. DATE <b>4/15/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>CARIDAD E. GONZALEZ, M.D.</b>				22d. ADDRESS <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/18/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ulrich</b>				25a. REC'D BY REGISTRAR <b>DATE APR 20 '60</b>		25b. REGISTRAR'S SIGNATURE <i>Ulrich E. Kline</i>	



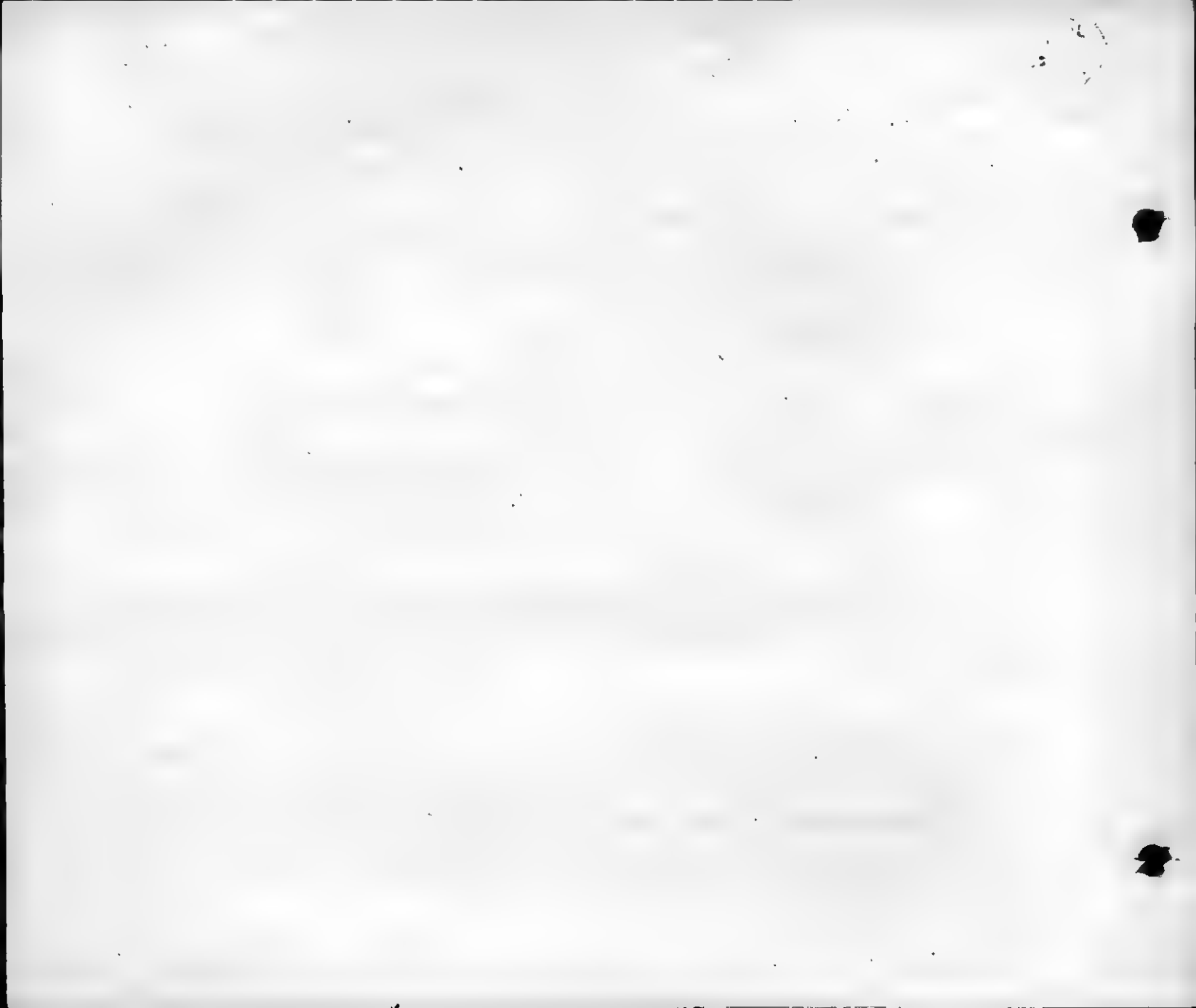
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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL: This certificate may be signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4252 CERTIFICATE OF DEATH 64181

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>57</u> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Hosp. Conv. Home</u>				/d. STREET ADDRESS <u>Lungersie Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Carrie Verna Davis</u> First Middle Last				4. DATE OF DEATH <u>April 23 1960</u> Month Day Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 21, 1887</u>	9. AGE (In years last birthday) <u>73</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry S. Charles</u>				14. MOTHER'S MAIDEN NAME <u>Louise Jenkins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Thomas Lee Davis</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis - Adenocarcinoma</u> 1960. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma ascending colon</u> 3 yrs. DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>1957</u> to <u>1960</u> , that (I) (the hospital) saw the deceased alive on <u>April 23, 1960</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>C. Vernon Williamson</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>C. VERNON WILLIAMSON</u>				22d. ADDRESS <u>4508 Edmondson Village - (29)</u>			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/26/60</u>		<u>London Park</u>		<u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Ruth Jordan</u> ADDRESS <u>28</u>				25a. REC'D BY REGISTRAR DATE <u>APR 27 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

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15M 9/59

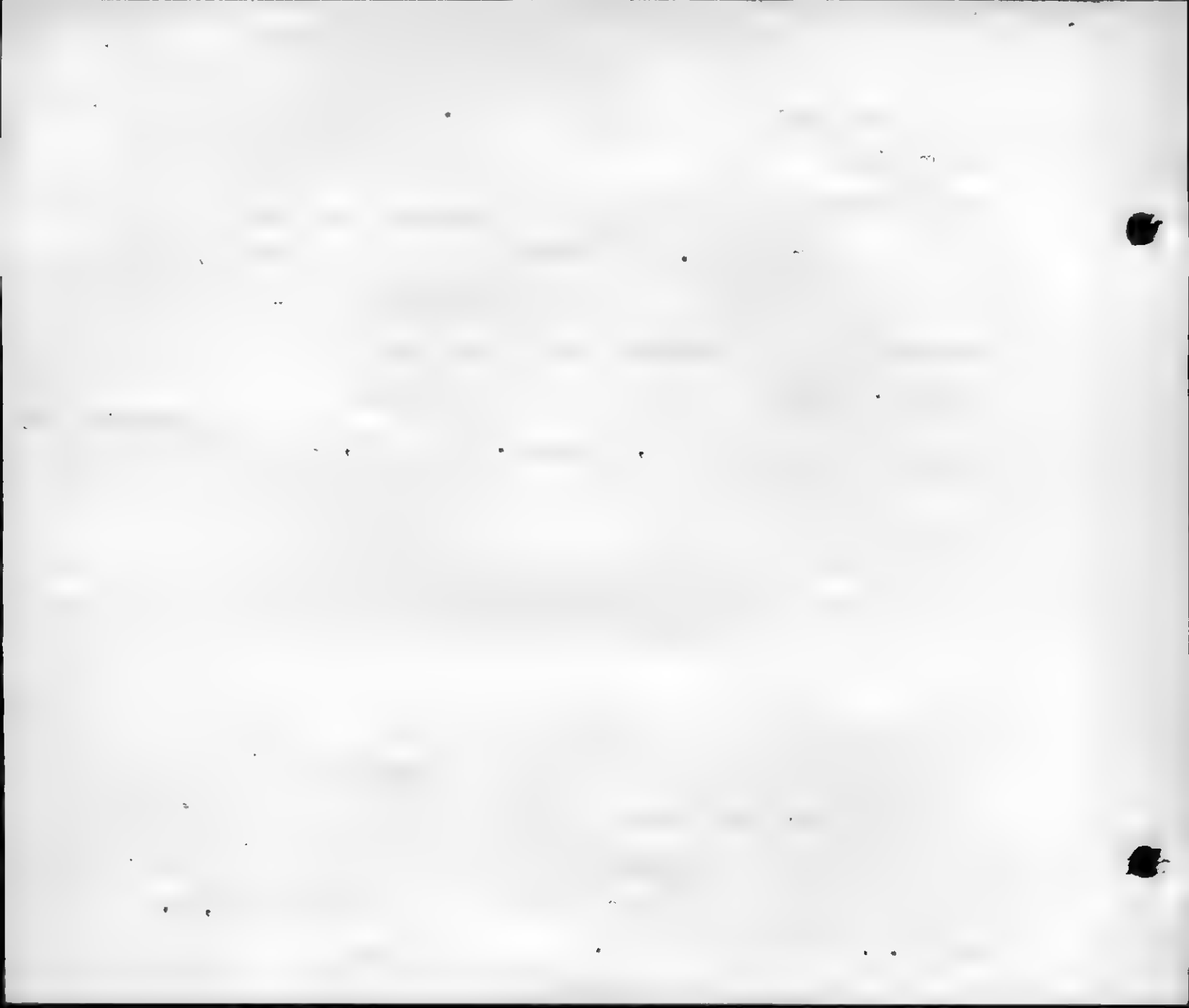
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1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4253 CERTIFICATE OF DEATH

04182

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>429 Academy Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF (Type or print) <b>John J. Davis</b>				4. DATE OF DEATH <b>April 3/60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 10/89</b>	
9. AGE (In years last birthday) <b>71</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Thomas E. Davis</b>				14. MOTHER'S MAIDEN NAME <b>Mary Haas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>214 40, 4492</b>			
17. INFORMANT Address <b>Catonsville 28</b> <b>214 40, 4492 Mrs. Ida Davis, 429 Academy Road</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1 Occlusion Coronary</b> DUE TO (b) <b>3 hrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/15/54</b> to <b>4/3/60</b> that (I) (we) last saw the deceased alive on <b>4/3/60</b> and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>E. J. Mendelis</b>				22b. DATE SIGNED <b>4/4/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>E. J. Mendelis</b>				22d. ADDRESS <b>651 N Beutaten St</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 6/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore 29, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Witzke F.D. 4101 Edmondson Ave.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 5 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



4254  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garrison</i>		c. LENGTH OF STAY IN TB <i>70 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <i>Railroad Ave.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Spurgeon David Davis</i>		4. DATE OF DEATH Month Day Year <i>4 4 1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 26, 1888</i>
9. AGE (In years last birthday) <i>71</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardener</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Private</i>	
11. BIRTHPLACE (State or foreign country) <i>Garrison, Md</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Jarrett Davis</i>		14. MOTHER'S MAIDEN NAME <i>Mary Alice Bell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes No or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>0</i>	
17. INFORMANT <i>Mrs. Alice Smith</i>		Address <i>Garrison, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic C.V.D.</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb-8</i> , 19 <i>60</i> , to <i>4-4</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>3-31</i> , 19 <i>60</i> , and that death occurred at <i>10:45 AM</i> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Charles H. Williams</i> M.D. <i>1632 Reisterstown Road</i> PHYSICIAN'S NAME (Type) <i>Charles H. Williams</i> <i>Pikesville 8, Md.</i>			
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-8-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Lukes Cemetery</i>	22d. LOCATION (City, town or county) (State) <i>Reisterstown, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mr. James A. Henry</i>		24a. REC'D BY REGISTRAR DATE <i>APR 5 '60</i>	
ADDRESS <i>578</i>		24b. REGISTRAR'S SIGNATURE <i>S. Kraus</i>	

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
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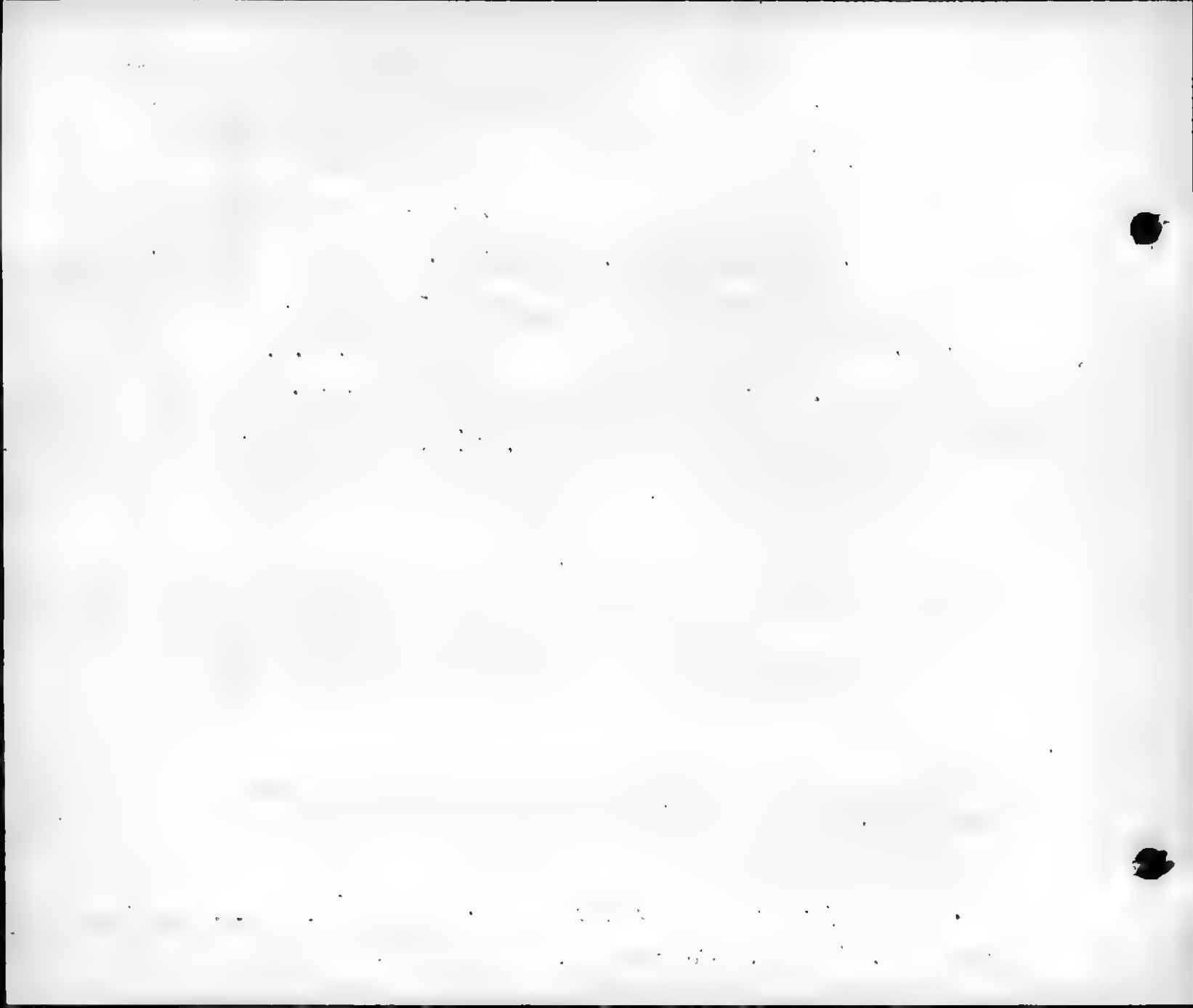
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4255

CERTIFICATE OF DEATH

Reg. Dist. No. 184

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2701 Wildberger Avenue</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i> d. STREET ADDRESS <i>2701 Wildberger Avenue</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mrs. Margaret</i> Middle <i>T.</i> Last <i>De Graw</i>		4. DATE OF DEATH Month <i>April</i> Day <i>4th</i> Year <i>1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 1, 1879</i>
9. AGE (In years last birthday) <i>81</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George W. Britt</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Butler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Mr. Elmer De Graw, 2701 Wildberger Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>422.2</i> DUE TO <i>Degenerative heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>old age</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1952</i> to <i>4</i> , <i>1960</i> , that I last saw the deceased alive on <i>ag 2</i> , <i>1960</i> , and that death occurred at <i>1:25 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Harold J. Burns</i> M.D.		ADDRESS (Street, city or town, State) <i>8106 Harford Rd.</i> DATE SIGNED <i>4-4-60</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REINTERMENT (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>4/6/60</i>	<i>Parkwood Cemetery</i>	<i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>		DATE <i>APR 6 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**4256 CERTIFICATE OF DEATH**

64185

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u></u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dorchester</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		2011	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Softleigh Nursing Home</u>		d. STREET ADDRESS <u>4409 Just Park Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Pickman</u> Last <u></u>		4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1960</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/7/1901</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Solomon Pickman</u>		14. MOTHER'S MAIDEN NAME <u>Lena</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u>219-32-008</u>		17. INFORMANT <u>Beatrice Pickman</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stroke - C.V.A. Cerebral Thromb</u> DUE TO (c) <u>H. A. S. H. D.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 week</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS A JTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u></u> o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/7</u> 19 <u>50</u> to <u>4/22</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>4/22</u> 19 <u>60</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Israhel Zinberg</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>ISRAEL ZINBERG</u>		22d. ADDRESS <u>2320 Eutaw Place</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/27/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		23d. LOCATION (City, town, or county) (State) <u>Dorchester Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sol. L. Luman</u>		ADDRESS <u>6010 Just Park Dr.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 26 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4257

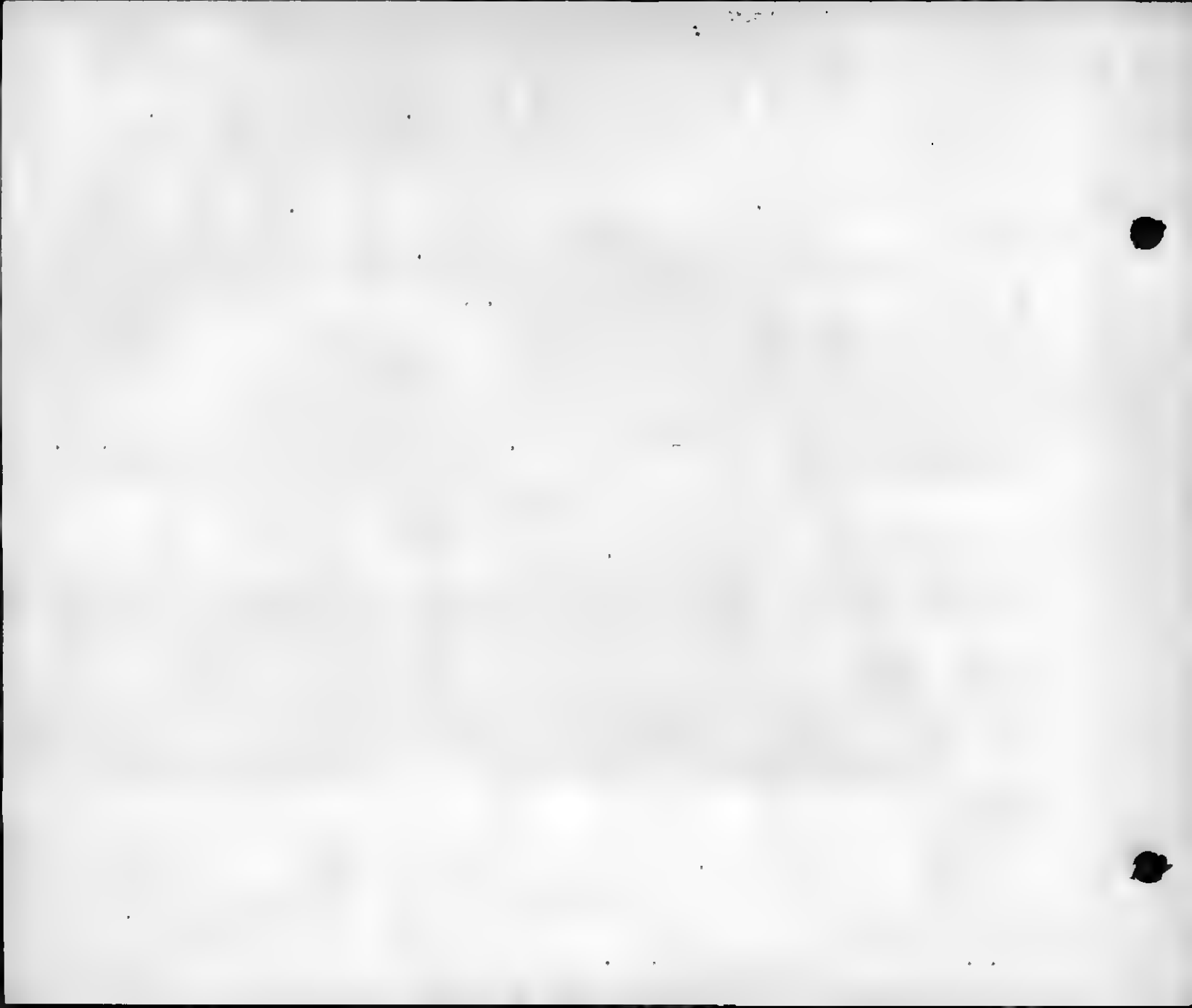
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

64186

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>324 Pleasant Hill Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Adam</b> Last <b>Diehl Sr.</b>		4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 5, 1899</b>
9. AGE (In years and birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance man at Hospital</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Adam Diehl</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Nace</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-20-9039</b>	
17. INFORMANT <b>Mrs. Rosie Turnbaugh</b>		Address <b>Reisterstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic C-V Disease</b> DUE TO (c) <b>none</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>none</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>D. D. Caples</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>4-4-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/7/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Reisterstown Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>Reisterstown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F.Eline &amp; Sons</b>		ADDRESS <b>Reisterstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 5 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEF. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please enclose certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 should be used on burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A11 (4)  
15M 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**4258** **CERTIFICATE OF DEATH**

**05421**

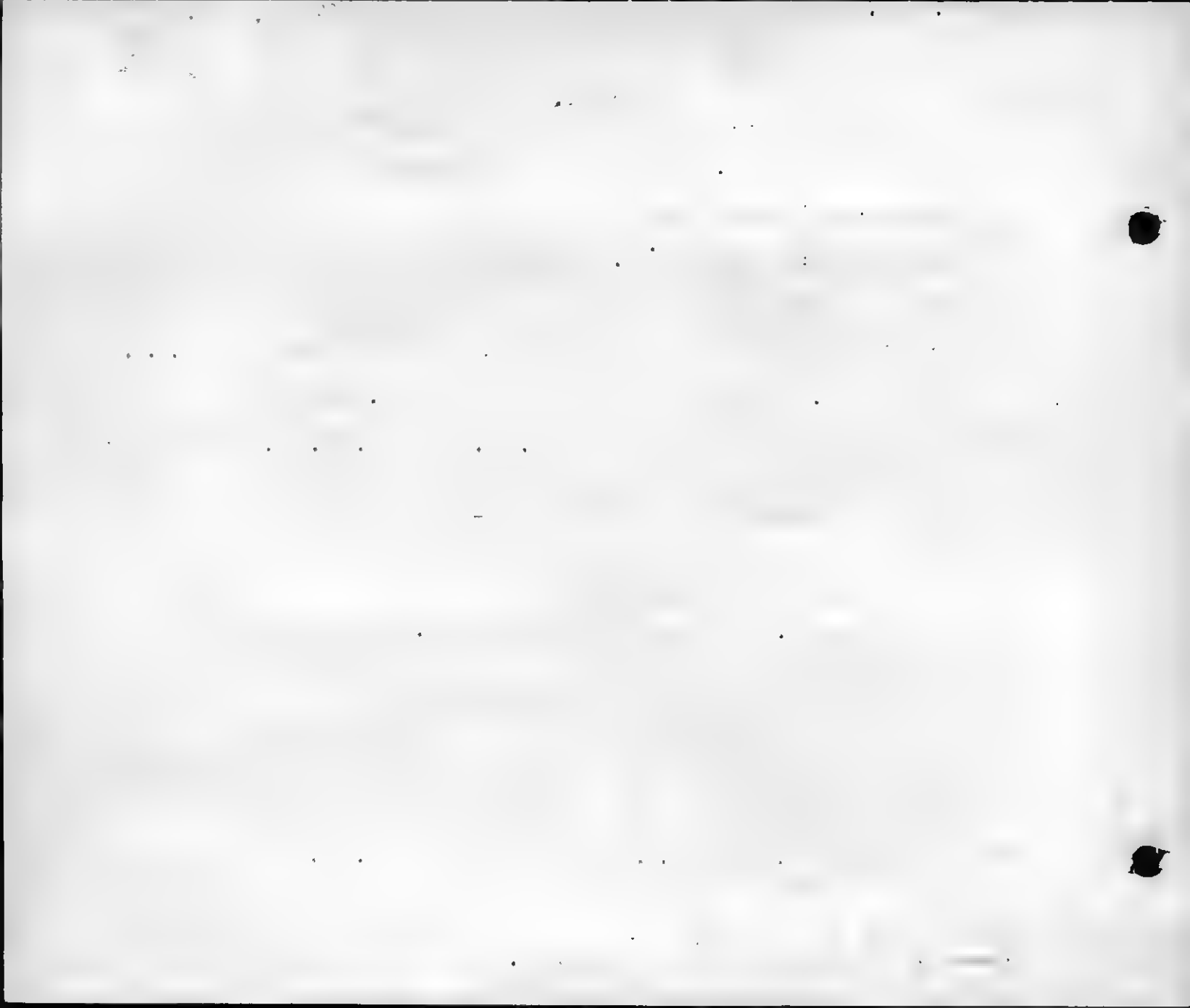
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>26 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>Easton</b>			
3. NAME OF DECEASED (Type or print) <b>Served As: JEAN W. N. DIFFENDERFER WOOLNORTH</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>9</b> Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <b>XX</b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/7/86</b>	9. AGE (In years last birthday) <b>73</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Christopher J. Hinricks</b>				14. MOTHER'S MAIDEN NAME <b>Ellen M. Bruehl</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>Clin. Rec. VAH, Balto. Md. Ft. Howard Division</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CARDIAC ARRHYTHMIA</b> 4-3-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE WITH OLD HEALED POSTERIOR INFARCTION</b> (c) <b>ARTERIOSCLEROSIS GENERALIZED</b>							INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>20 YEARS</b> <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS. ARTERIOSCLEROSIS OBLITERANS RT. LEG WITH GANGRENE OF FOOT</b>							19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>March 14 1960</b> to <b>April 9 1960</b> . That (we) last saw the deceased alive on <b>April 9 1960</b> and that death occurred at <b>7:45 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Arthur T. Faulk, M.D.</b>				22b. DATE SIGNED <b>4/10/60</b>		22c. PHYSICIAN'S NAME (Type) <b>ARTHUR T. FAULK, M.D.</b>	
22d. ADDRESS <b>VAH, BALTO. MD. FT. HOWARD DIVISION</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>4/13/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		23d. LOCATION (City, town, or county) (State) <b>Bladensburg, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frampton Carroll Undertakers</b>				25a. REC'D BY REGISTRAR <b>DATE MAY 23 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE **MAY 23 '60**

**Arthur S. Kraus**



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4259

CERTIFICATE OF DEATH

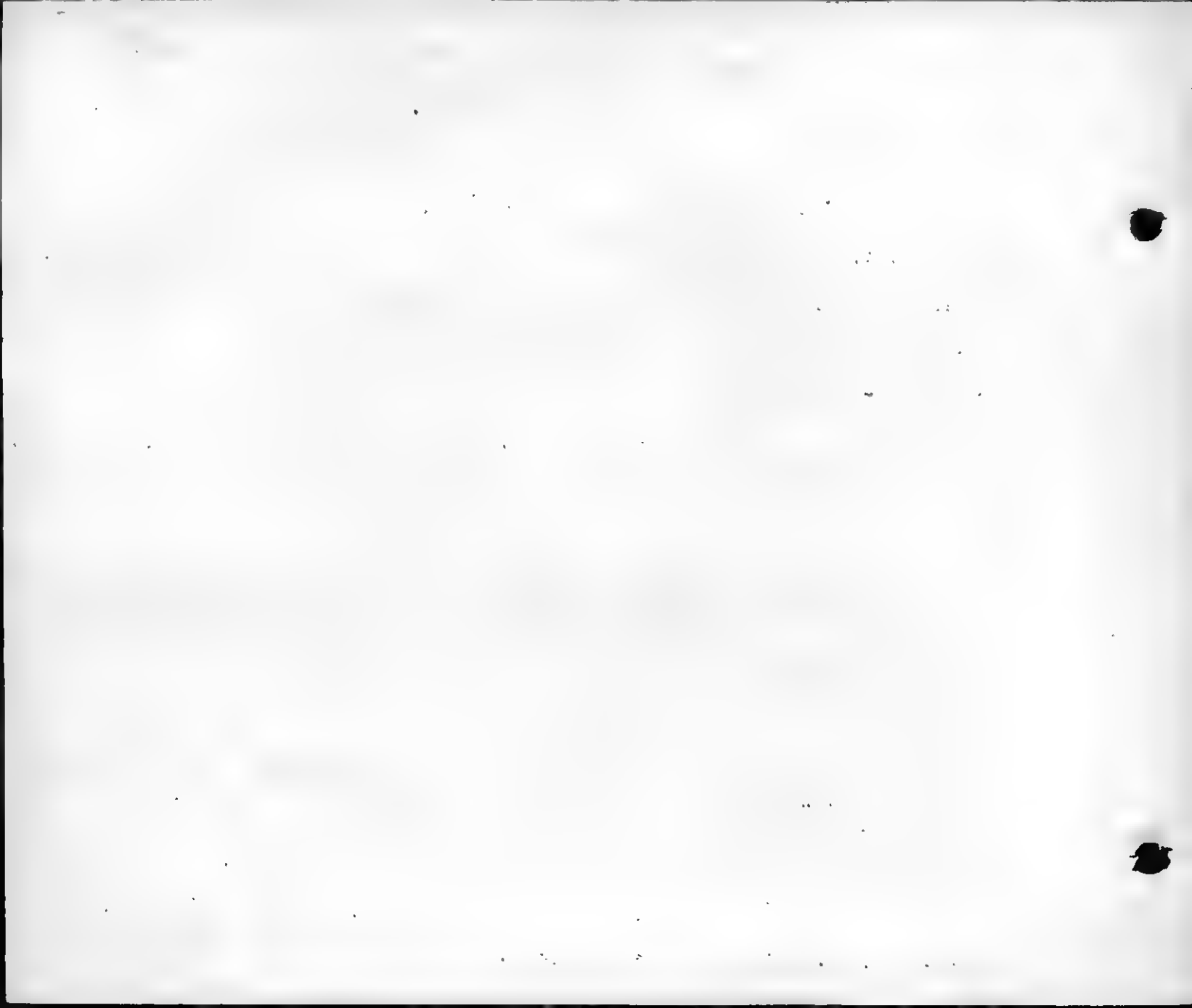
64187  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>826 Scarlett Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Paul Di Pino</u>		4. DATE OF DEATH Month Day Year <u>April 14th 19 60</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 3, 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Italy</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sebastian Di Pino</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Bonica</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-05-2416</u>	
17. INFORMANT <u>Mrs. Jennie Di Pino</u>		Address <u>826 Scarlett Drive.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-7</u> , 19 <u>60</u> , to <u>4-14</u> , 19 <u>60</u> ; that I last saw the deceased alive on <u>4-13</u> , 19 <u>60</u> , and that death occurred at <u>4:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sebastian Russo</u> M.D.		DATE SIGNED <u>5017 Harford Road</u>	
PHYSICIAN'S NAME (Type) <u>SEBASTIAN RUSSO MD</u>		<u>5017 HARFORD ROAD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/18/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR <u>APR 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other certificate is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 4188										
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
c. LENGTH OF STAY IN 1b 4mth 4dys					d. STREET ADDRESS 6517 Vincennes Avenue					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Paul Augusta Ditman					4. DATE OF DEATH Month Day Year April 1 19 60					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 12, 1887		9. AGE (In years last birthday) 72 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		IF UNDER 1 YEAR Months Days Hours Min.		
13. FATHER'S NAME Joshua Ditman					14. MOTHER'S MAIDEN NAME Hannah Cogrig					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-07-7458		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broncho Pneumonia 904.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>11th rib fracture</u> DUE TO (c) Fracture Right Hip - Accident										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) On 3-17-60 reduction and internal fixation with Smith-Petersen nail and side plate was performed under spinal anesthesia.										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. was found on 3-7-60 with pain in right hip. X-ray revealed intertrochanteric frac. of right femur - circumstances of injury unknown.								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 3-7 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) Catonsville 28, Maryland		(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE George R. Kieffer					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) George R. Kieffer, M. D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 4/1/60		22c. NAME OF CEMETERY OR CREMATORY Lorraine Cem.		22d. LOCATION (City, town, or county) Woodlawn, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Am. J. Tietener & Sons - Balto 17					24a. REC'D BY REGISTRAR DATE APR 4 '60		24b. REGISTRAR'S SIGNATURE S. Anaw			





## 4261 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenarm Road</b>		e. STREET ADDRESS <b>Glenarm Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sister Mary Genevieve Dittmann</b>		4. DATE OF DEATH Month Day Year <b>April 21 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 19, 1875</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Religious</b>	
11. BIRTHPLACE (State or foreign country) <b>West Prussia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Dittmann</b>		14. MOTHER'S MAIDEN NAME <b>Anna Mann</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Sister M. Peter Fourrier</b>		Address <b>Notch Cliff, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary</b> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <b>Feb. 1954</b> to <b>April 1960</b> , that I last saw the deceased alive on <b>April 12th 1960</b> , and that death occurred at <b>12:25 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles F. O'Donnell M.D.</b>		ADDRESS (Street, city or town, state) <b>7501 York Road Towson 4, Md.</b> DATE SIGNED <b>4/21/60</b>	
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4/23/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Village Maus Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Notch Cliff m. Towson, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Zoller</b>		ADDRESS <b>6224 Eastern Ave. Ma</b>	24a. REC'D BY REGISTRAR <b>APR 25 '60</b>
			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



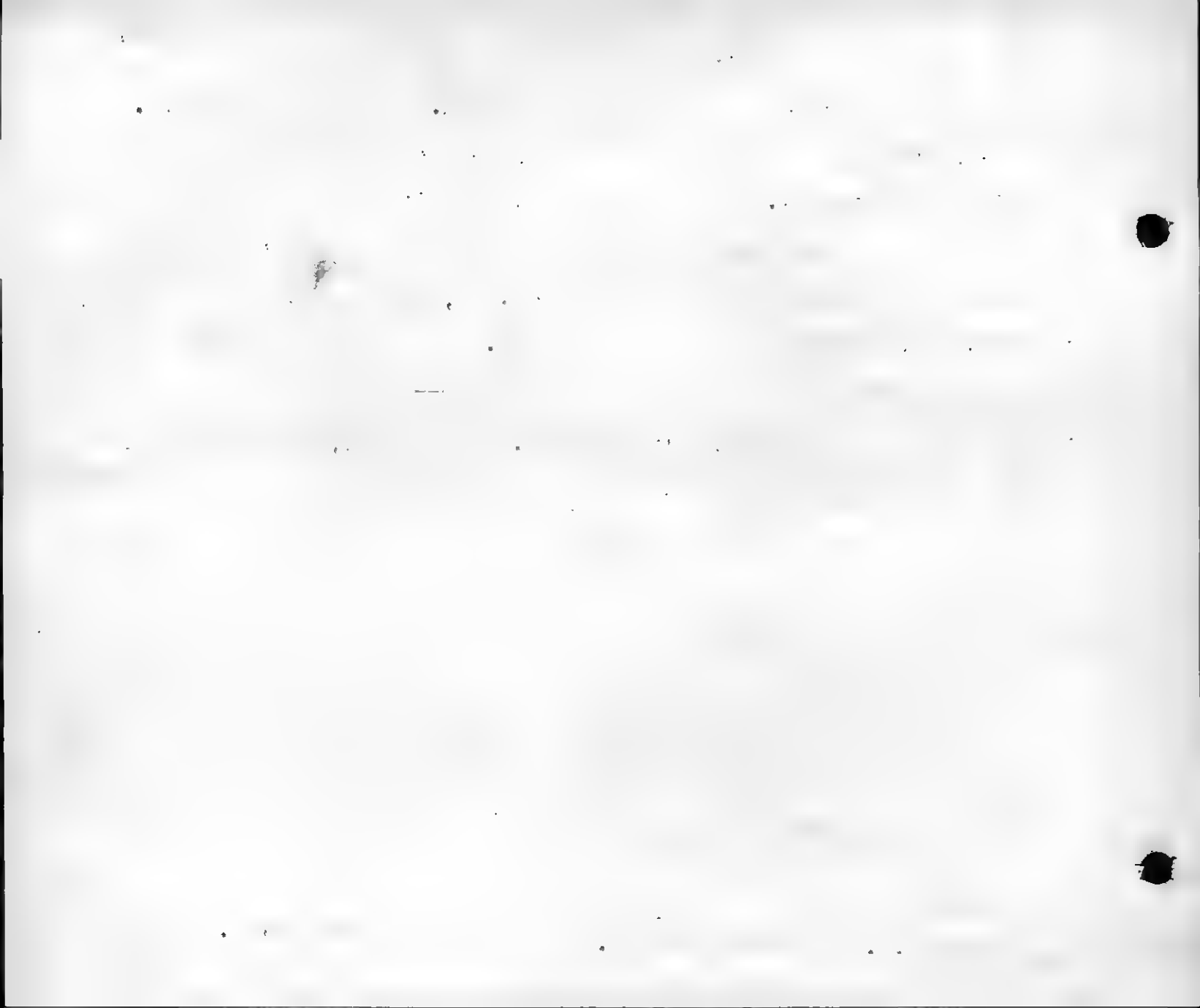
## 4262 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Ma.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5421 Whitlock Rd.</b>		d. STREET ADDRESS <b>5421 Whitlock Rd</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>William</b> Last <b>Dodd</b>		4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 10, 1880</b>
9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Va.</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Dodd</b>		14. MOTHER'S MAIDEN NAME <b>Lucy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>		16. SOCIAL SECURITY NO. <b>215 03 8742</b>	
17. INFORMANT <b>Mrs. Beessie Dodd</b>		Address <b>5421 Whitlock Rd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>16 days</b> <b>2 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 14</b> , 19 <b>60</b> to <b>April 23</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>April 22</b> , 19 <b>60</b> , and that death occurred at <b>1:35 A.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>5501 Dorsey Park Ave</b> DATE SIGNED <b>4/23/60</b>			
ACTUAL SIGNATURE <b>Kennard Yaffe</b>		PHYSICIAN'S NAME (Type) <b>KENNARD YAFFE</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/26/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel</b>		22d. LOCATION (City, town, or county) (State) <b>Pasadena, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D.</b>		ADDRESS <b>101 Edmondson Ave.</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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VS A15 (4)  
15M 9/58

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4263 CERTIFICATE OF DEATH

64191

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Convalescent Home</b>		d. STREET ADDRESS <b>3720 Fait Ave. # 24.</b>	
3. NAME OF DECEASED (Type or print) <b>GEORGE M. DOTTERWEICH.</b>		4. DATE OF DEATH <b>April 24, 19 60.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 10, 1888</b>
9. AGE (In years last birthday) <b>71</b> yrs		IF UNDER 1 YEAR	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Tran. Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Andrew Dotterweich</b>	
14. MOTHER'S MAIDEN NAME <b>Mary K. Gephardt.</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO <b>-----</b>		17. INFORMANT <b>Wilhelmina E. Dotterweich</b> Address <b>Same.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular Hemorrhage</b> DUE TO <b>Arteriosclerotic Vascular Dis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 19 59</b> to <b>Apr. 19 60</b> , that I last saw the deceased alive on <b>Apr. 5 60</b> , and that death occurred at <b>6:00 AM</b> . I declare the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank T. Kasik</b>		ADDRESS (Street, city or town, state) <b>9005 Harbor Rd. Balto Md</b>	
PHYSICIAN'S NAME (Type) <b>FRANK T KASIK</b>		DATE SIGNED <b>4/25/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/27/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>4430 Belair Rd. Balto Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Zeiler</b>		24a. REC'D BY REGISTRAR <b>APR 27 1960</b>	
ADDRESS <b>6224 Eastern Ave Balto Md</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4264 CERTIFICATE OF DEATH

64192  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>-</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>36 yr 8 mo 28 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>222 east Lafayette Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Or</b> Middle <b>Duncan</b> Last <b>Duncan</b>		4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 16, 1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>81</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Gangley</b>		14. MOTHER'S MAIDEN NAME <b>Mary Foxwell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Possible carcinoma of the bladder</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 5</b> , 19 <b>60</b> , to <b>April 5</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>April 5</b> , 19 <b>60</b> , and that death occurred at <b>4:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>4-5-60</b>			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>4/12/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Union of Maf.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anaheim Board</b>		24a. REC'D BY REGISTRAR DATE <b>APR 18 '60</b>	
ADDRESS <b>295, Greene St.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

420.0

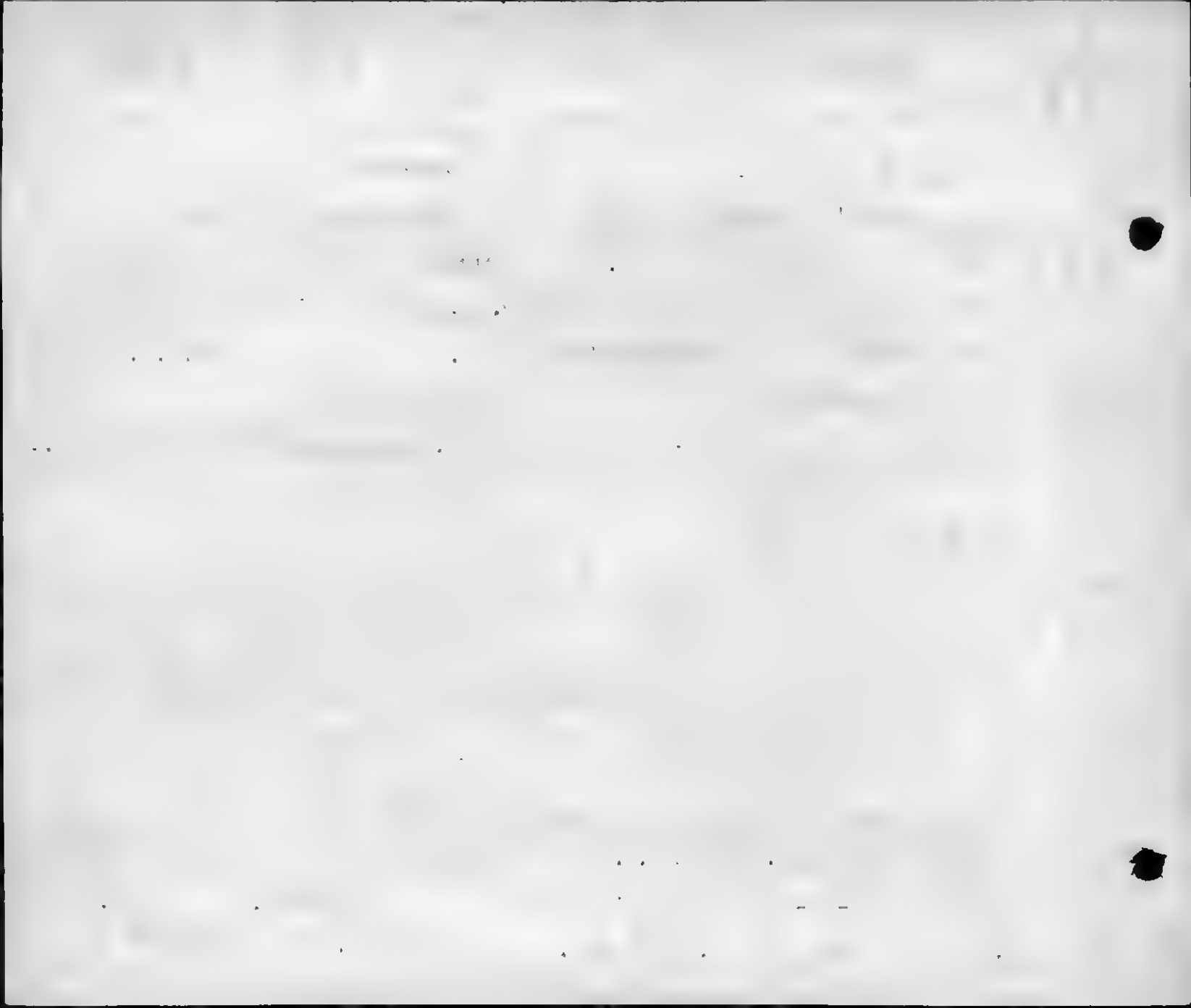


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

1 Item 18-21 Form 202 5-9-MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
4223 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 64193

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Haltherpe</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Carling's Brewery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>5106 Maple Park Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>SIDNEY V. DUNCAN</b>		4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>19 60</b>	
5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>Mar. 14, 1899</b>		9. AGE (In years last birthday) <b>61</b> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Iron Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>High Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Duncan</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Barrett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>209-09-6264</b>	
17. INFORMANT <b>Yvette M. Duncan</b>		Address <b>5106 Maple Park Ave.,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>422.1 Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W. Richard G. Pathologist</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-14-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		22d. LOCATION (City, town, or country) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR <b>G. Howard Strong</b>		ADDRESS <b>3207 W. North Ave.,</b>	
24a. REC'D BY REGISTRAR <b>APR 14 60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Smith</b>	

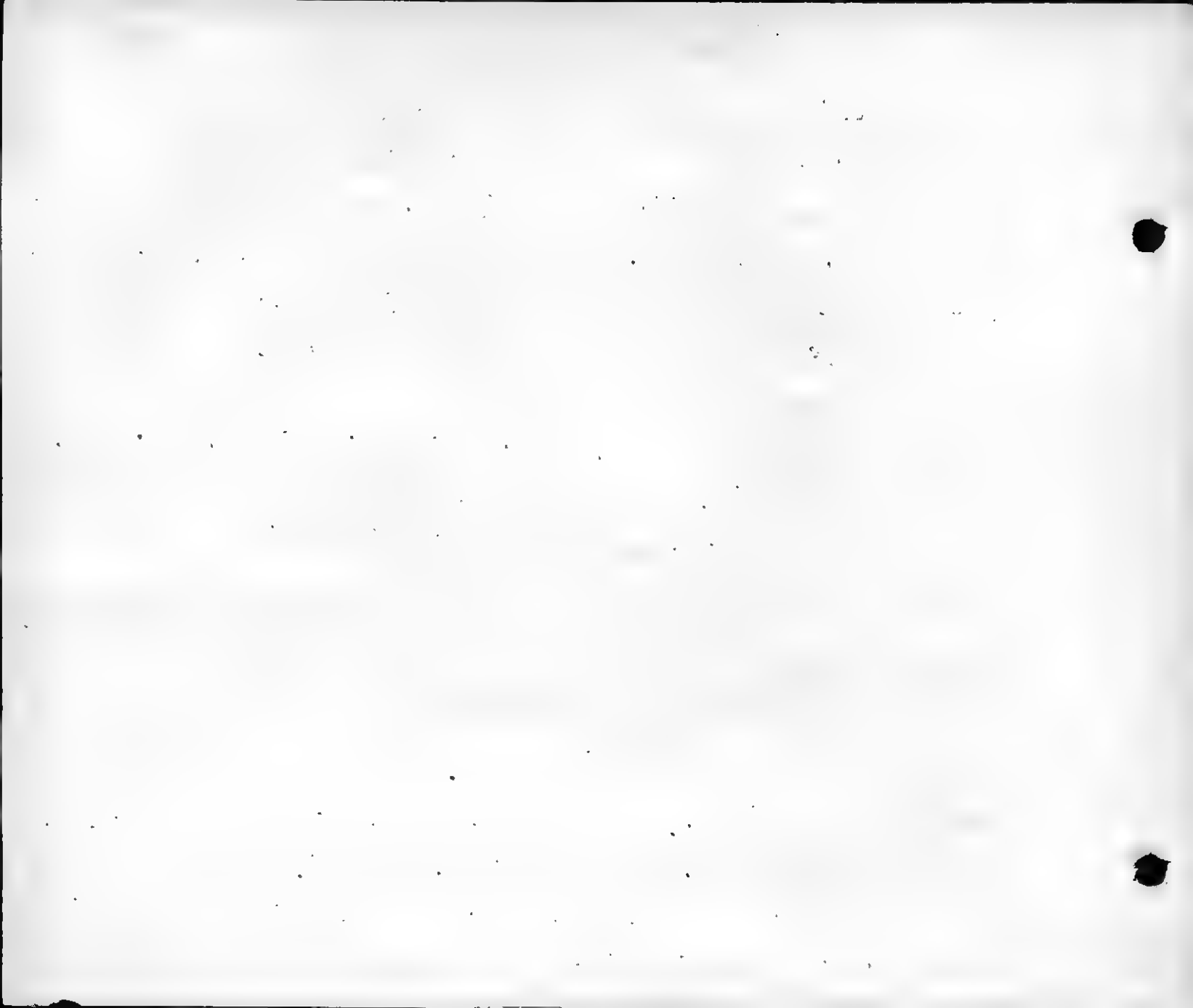


4265 CERTIFICATE OF DEATH

64194  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>V 14</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines</u>		d. STREET ADDRESS <u>1763 E. North Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Aimee J. Earlbeck</u>		4. DATE OF DEATH Month Day Year <u>April 2nd 19 60</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7, 1879</u>
9. AGE (In years last birthday) <u>80</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Allen Collison</u>		14. MOTHER'S MAIDEN NAME <u>Jeannette</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Informant</u> Address <u>Mrs. Elsie Herr 1763 E. North Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decomensation</u> <u>44 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Hypertensive Cardio-Vascular Disease</u> DUE TO (c) <u>15 yr.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-14-</u> , 19 <u>59</u> , to <u>4-2-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-1-</u> , 19 <u>60</u> , and that death occurred at <u>6:30 a. m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilmer K. Gallager</u>		ADDRESS (Street, city or town, state) <u>6209 Frederick Road</u> DATE SIGNED <u>4-2-60</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallager</u>		<u>Baltimore-28, Md.</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/6/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>APR 5 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







# 1 \* FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in item 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

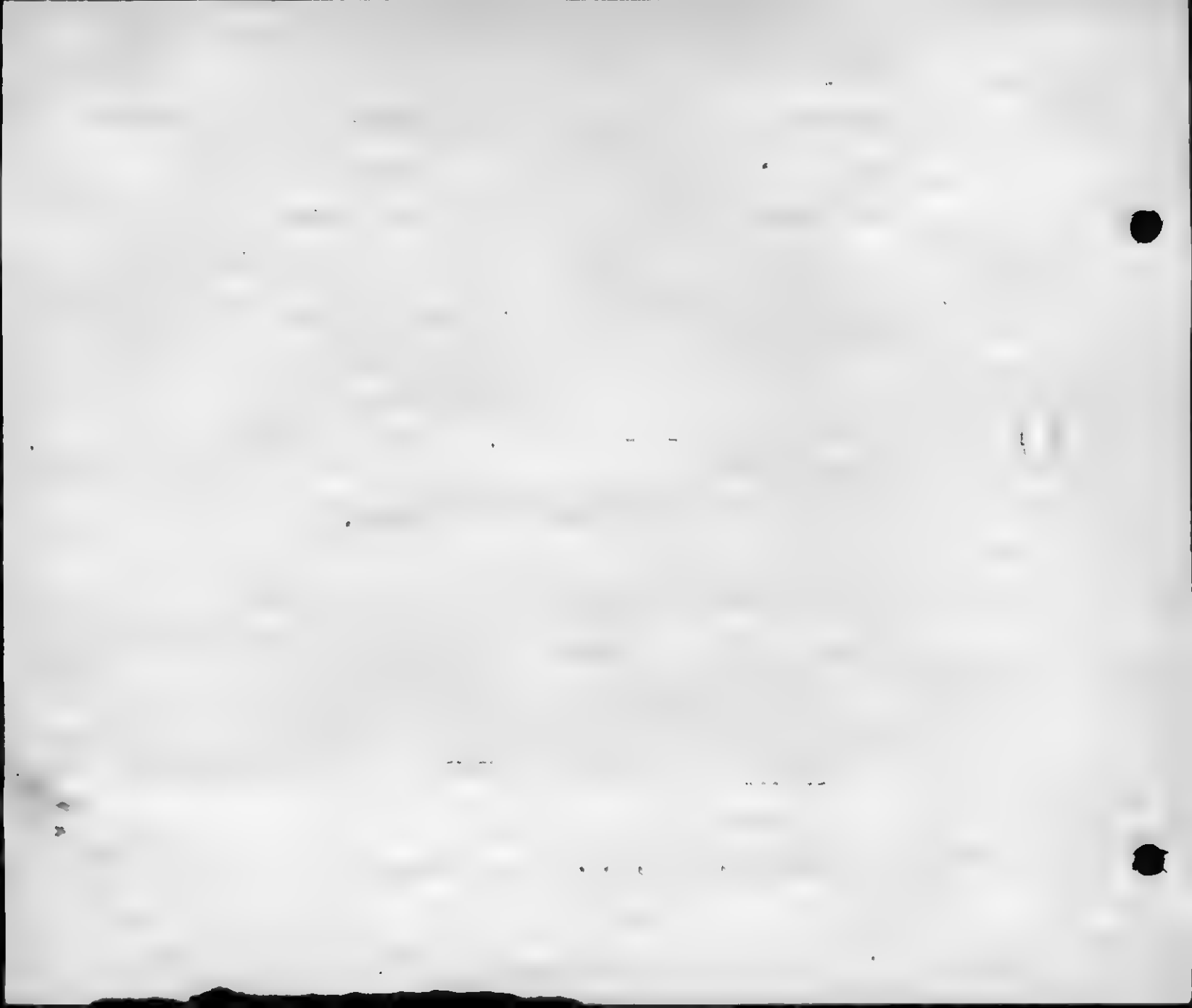
## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### 4267 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64196

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <b>7600 Hillsway</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7600 Hillsway</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EDWIN GORDON ESTEP</b>				4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 10, 1908</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b>00</b> Min.		11. IF UNDER 24 HRS. Hours <b>00</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auditor for American Oil Co</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>			
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Morton Estep</b>				14. MOTHER'S MAIDEN NAME <b>Lydia Smith</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>				16. SOCIAL SECURITY NO. <b>212-01-7279</b>			
17. INFORMANT <b>Mrs. Evelyn Estep</b>				Address <b>7600 Hillsway Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Thrombosis</b> DUE TO <b>Arteriosclerotic Heart Disease.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Petty</b>				M.D. <b>Charles S. Petty, M.D.</b>			
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>				DATE SIGNED <b>4/26/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/29/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR <b>Leonard J. Ruck</b>				ADDRESS <b>5305 Harford Road #14</b>			
24a. REC'D BY REGISTRAR <b>APR 27 '60</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			

MEDICAL CERTIFICATION





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH															
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
4268 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 64197															
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b> c. LENGTH OF STAY IN <b>1b</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Bethlehem Steel Co. Dispensary</b>						2. USUAL RESIDENCE (Where deceased lived, if institution's Residence before admission) a. STATE <b>Maryland</b> <b>Baltimore</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b> d. STREET ADDRESS <b>501 "E" Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Milton McKinley</b> First Middle Last 4. DATE OF DEATH <b>4 29 1960</b> Month Day Year						5. SEX <b>Male</b> 6. COLOR OR RACE <b>Wh.</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>Sept. 5, 1900</b> 9. AGE (In years and birthday) <b>59</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boiler Foreman</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>						11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Andrew J. Estes</b>						14. MOTHER'S MAIDEN NAME <b>Lucy J. Walton</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>213-09-1587</b>						17. INFORMANT <b>Mrs. Addie B. Estes - same as #4</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon Monoxide Poisoning</b> <b>973.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>DUE TO</b> (e), stating the underlying cause last. PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>												INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Ran hose from exhaust into car</b>			
20c. TIME OF INJURY Month, Day, Year <b>4-29-60</b> Hour a.m. p.m.						20d. INJURY OCCURRED <b>While at work</b> <input checked="" type="checkbox"/> <b>Not While at work</b> <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>5th Street parking lot - Sparrows Point-19, Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <b>M B Davis</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <b>4-29-60</b>			
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						22b. DATE THEREOF <b>5-2-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>				22d. LOCATION (City, town, or country) (State) <b>Baltimore County Md.</b>			
23. FUNERAL DIRECTOR <b>Walter Brooks Bradley, Inc., -Dundalk 22</b> ADDRESS						24a. REC'D BY REGISTRAR <b>MAY 3 '60</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64198

Reg. Dist. No.

4232

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> c. LENGTH OF STAY IN 1b <b>Reisterstown</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Knox Ave.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville, Md.</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>Lewis</b> Last <b>Fishpaw</b>		4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19, 1942</b>
9. AGE (In years last birthday) <b>17</b> yrs.		IF UNDER 1 YEAR Months <b>17</b> Days <b>19</b>	IF UNDER 24 HRS. Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Contracting Firm</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Gilbert O. Fishpaw Sr.</b>	
14. MOTHER'S MAIDEN NAME <b>Thelma L. Hudson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Mrs. Gilbert O. Fishpaw, Cockeysville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia due to pressure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>On Rt. jaw &amp; Larynx - Fractured mandible</b> DUE TO (c) <b>Auto accident</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cor upset on curve in Rd.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Cor upset on curve in Rd.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>6:30</b> P. M. <b>Apr 24 1960</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road</b>	20f. (City or town) <b>Reisterstown</b> (County) <b>Baltimore</b> (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 27, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Poplar Grove Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cockeysville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Sullivan</b>		24a. REC'D BY REGISTRAR <b>APR 28 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		24c. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

MEDICAL CERTIFICATION

SIGNATURE

EXAMINER'S NAME (Type)

**D. D. Caples**

**D. D. CAPLES**

M.D.

CHIEF MEDICAL EXAMINER ☐

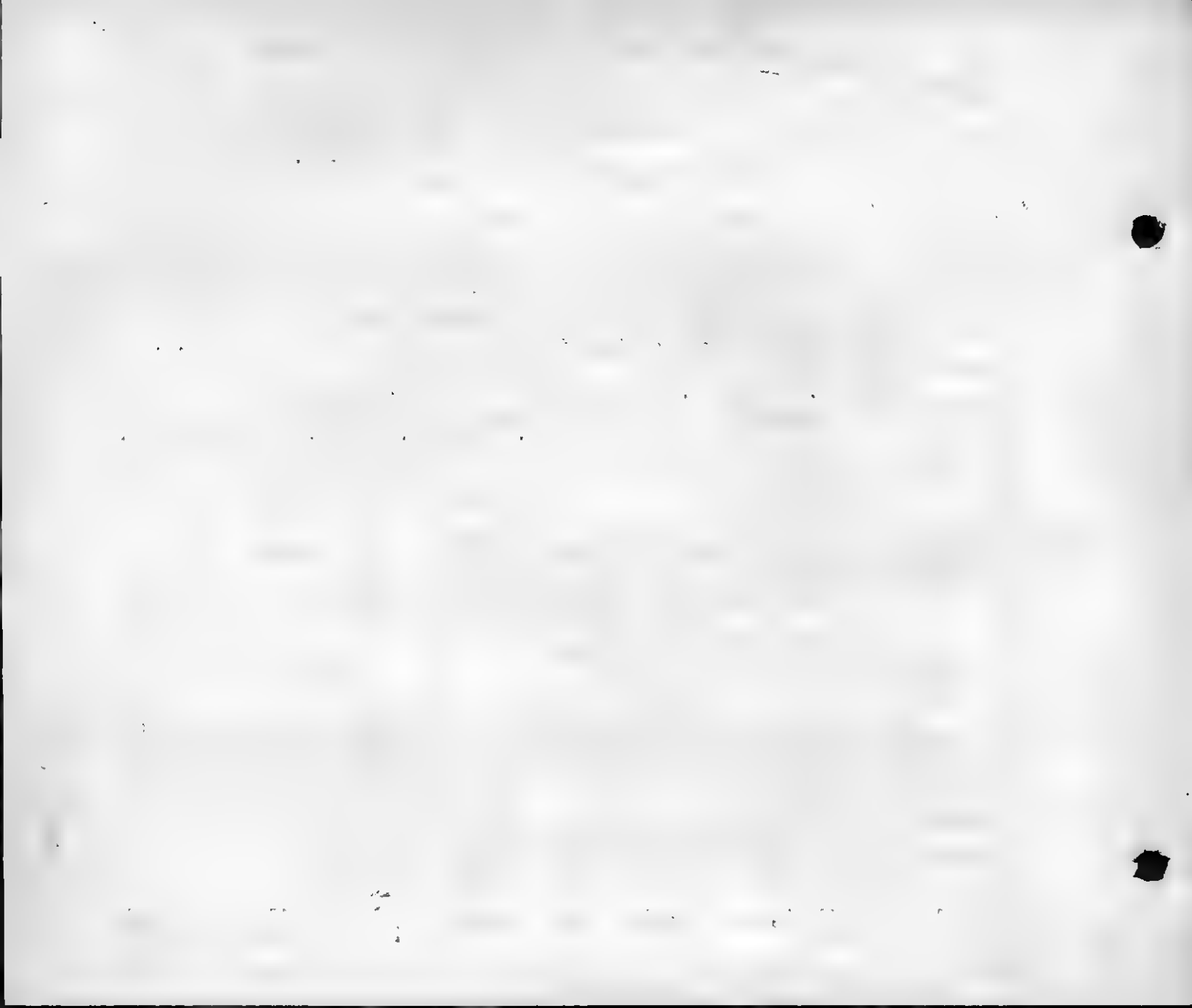
ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

**4-24-60**

TO DE: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please see  
cure certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be  
forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation,  
or removal.



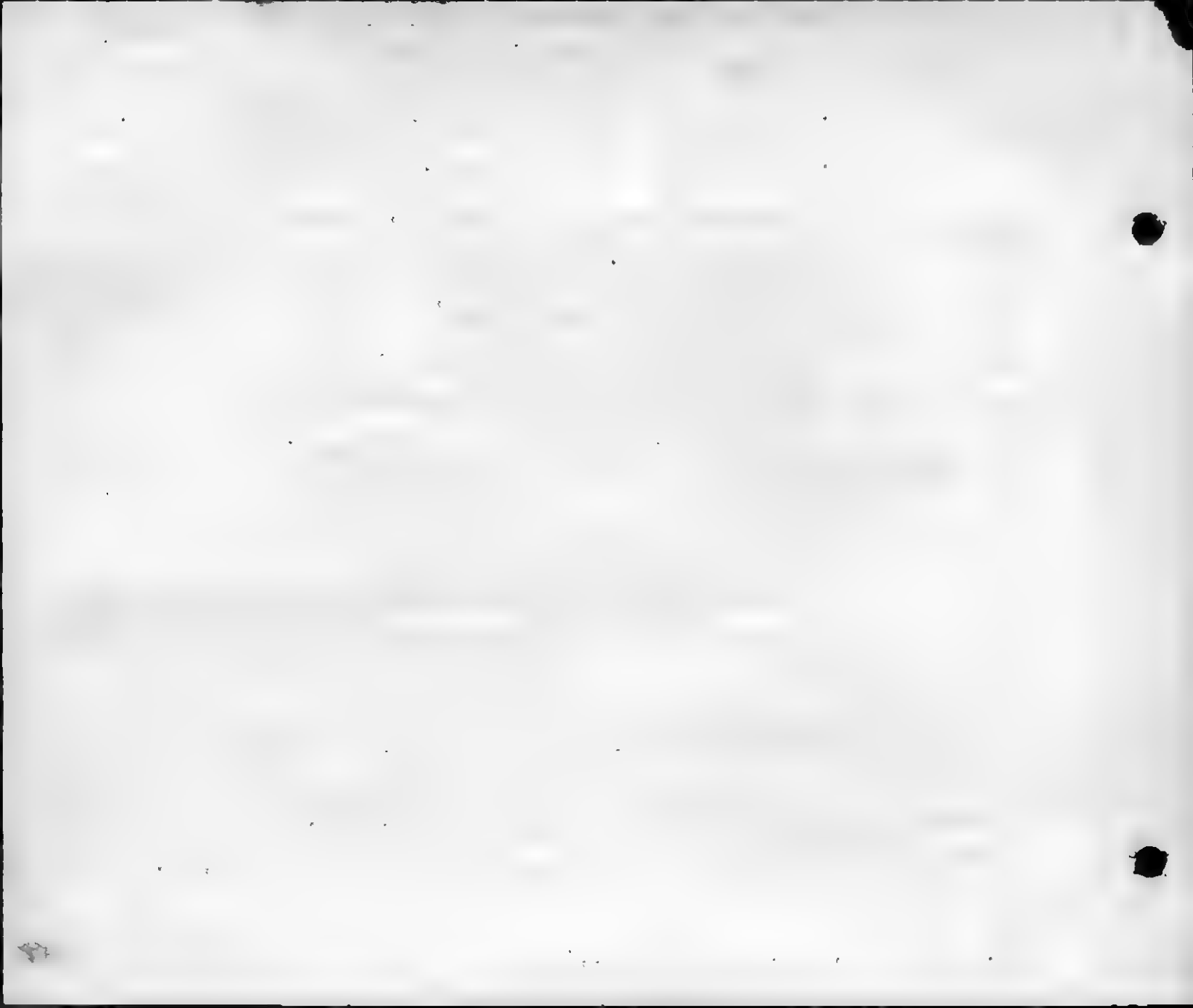
CERTIFICATE OF DEATH

Reg. Dist. No.

4269

1. PLACE OF DEATH a. COUNTY <b>Baltio.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltio.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltio.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltio. 3501 Berywn Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stella Maris Hospice</b>		d. STREET ADDRESS <b>Towson 4, Maryland</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>E.</b> Last <b>Folan</b>		4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Worcester, Mass</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Morgan Folan</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Costello</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-28-1642</b>	
17. INFORMANT <b>Sister Mary Kristine, Stella Maris Hospice</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b> DUE TO <b>Pulmonary Edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiac Renal</b> DUE TO <b>Vascular Disease</b> (c) <b>16 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-12</b> , 19 <b>56</b> , to <b>4-5</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>April 4, 1960</b> , and that death occurred at <b>3:45</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7501 York Rd.</b> DATE SIGNED <b>4/5/60</b>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell M.D.</b>		PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D.</b>	
22a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-7-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. C. O'k-Towson, Inc., 1050 York Road, Towson</b>		24a. REC'D BY REGISTRAR DATE <b>APR 7 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. H.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

Item 23 File G261 4/25/60 **CERTIFICATE OF DEATH**

64201

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>9 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>Galesville</b>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>E.</b> Last <b>FOOTE</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>16</b> Year <b>19 60</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>2/1/22</b>
9 AGE (In years last birthday) <b>38</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>	
11 BIRTHPLACE (State or foreign country) <b>Parole, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Foote</b>		14. MOTHER'S MAIDEN NAME <b>Liza Denton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16 SOCIAL SECURITY NO. <b>WW II 214-05-2187</b>	
17. INFORMANT <b>Clin. Rec. VAH, Balto. Md. Ft. Howard Division</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CHRONIC PYELONEPHRITIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HYPERTENSION</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 7</b> , 19 <b>60</b> , to <b>April 16</b> , 19 <b>60</b> , that (we) last saw the deceased alive on <b>April 16</b> , 19 <b>60</b> , and that death occurred at <b>4:15 PM</b> , the causes and an the date stated above.			
22a. SIGNATURE <b>Ernest O. Brown, M.D.</b>		22b. DATE SIGNED <b>4/16/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>ERNEST O. BROWN, M.D.</b>		22d. ADDRESS <b>VAH, BALTO. MD. FT. HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 20, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Chews Memorial Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Owensville, Maryland</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Bernard Hardesty</b>		25a. REC'D BY REG STRAR <b>DATE APR 19 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>			

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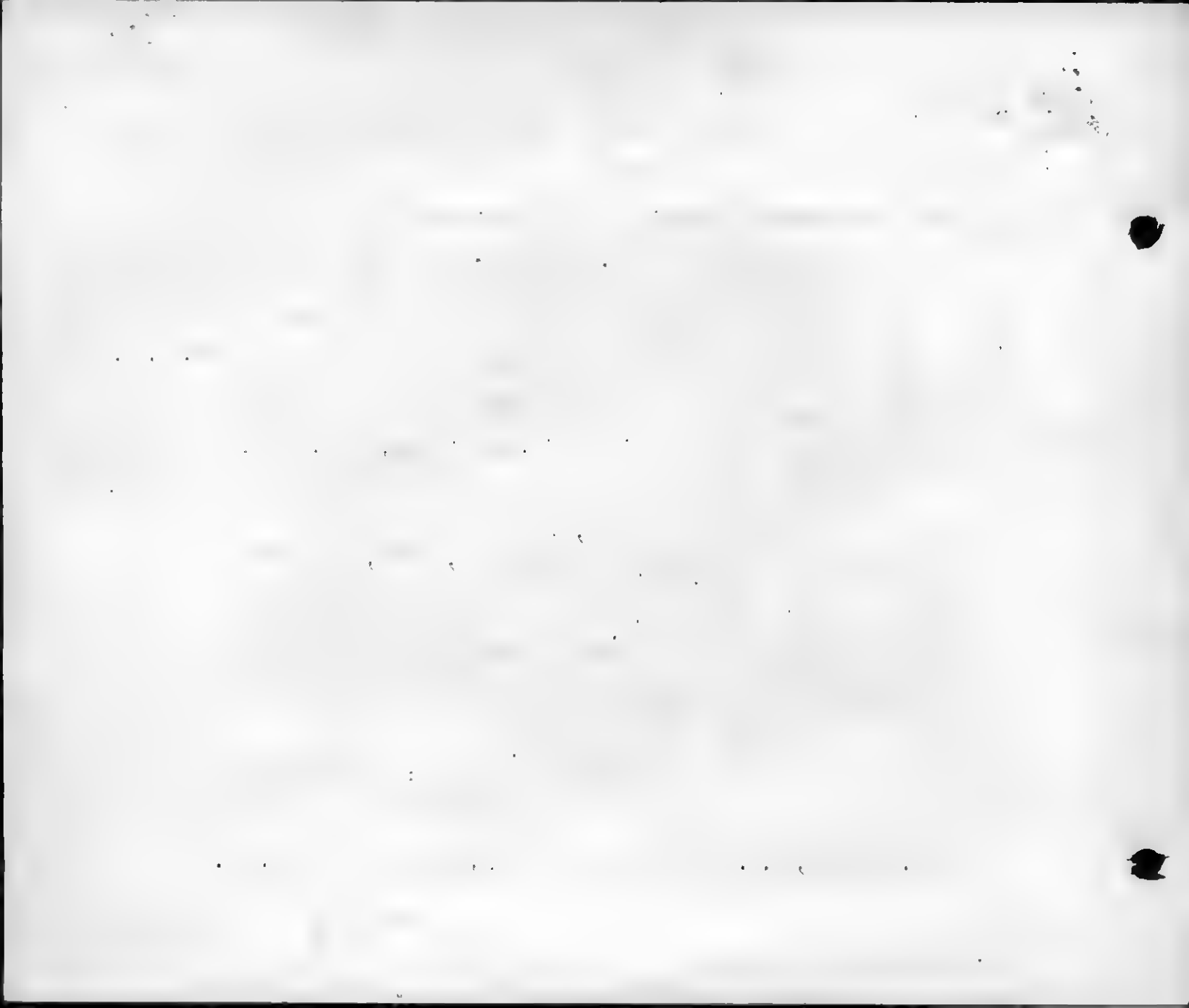
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

4271

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

64202

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
c. LENGTH OF STAY IN 1b <b>56 Days</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>Altamont Hotel Eutaw and Lanvale Streets</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>FERREL B. FOSTER</b>				4. DATE OF DEATH Month Day Year <b>April 21 19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>September 6, 1902</b>	9. AGE (n years last birthday) <b>57 yrs</b>	10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City Jail</b>		11. BIRTHPLACE (State or foreign country) <b>Joplin, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Neil Foster</b>				14. MOTHER'S MAIDEN NAME <b>Melissa Worrell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO <b>309-07-3772</b>			
17. INFORMANT <b>Clin. Records, VAH, Balto. 18, Md. Ft. Howard Division</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>INTESTINAL OBSTRUCTION</b> DUE TO <b>ADENOCARCINOMA, CECUM</b> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last (b) <b>EXTENSIVE METASTATIC ADENOCARCINOMA, LIVER, PARAAORTIC AND REGIONAL LYMPH NODES</b> (c) <b>Pulmonary congestion and edema. Arteriosclerosis, generalized. Aortic aneurysm, abdominal, old.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>  <b>OLD</b>  <b>OLD</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary congestion and edema. Arteriosclerosis, generalized. Aortic aneurysm, abdominal, old.</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>Feb. 25, 1960</b> to <b>April 21, 1960</b> , that (1) (we) last saw the deceased alive on <b>April 21 1960</b> , and that death occurred at <b>5:10 PM</b> from the causes and on the date stated above							
22a. SIGNATURE <b>John D. Talbert, M.D.</b>				22b. DATE SIGNED <b>4/22/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M.D.</b>				22d. ADDRESS <b>VAH, BALTIMORE 18, Md., FT. HOWARD DIVISION</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-25-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc.</b>				25a. RECEIVED BY REGISTRAR <b>APR 27 1960</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



4272

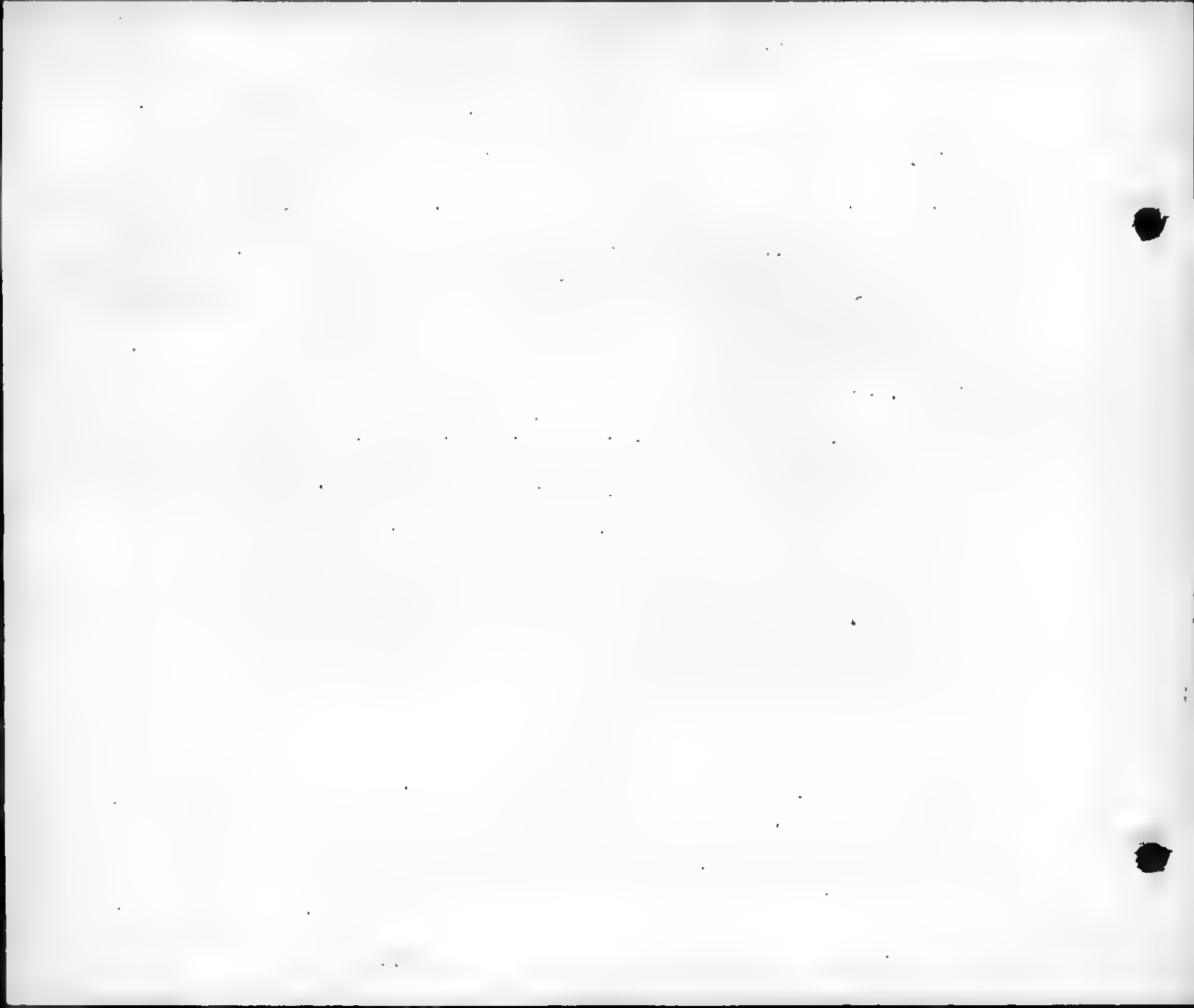
## CERTIFICATE OF DEATH

Reg. Dist. 4203

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cwings Mills</u> c. LENGTH OF STAY IN 1b <u>8 Months</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Traing School</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>413 N. Gilmore Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Emil</u> Middle <u>Cephas</u> Last <u>Fowlkes</u>			4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1960</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 12, 59</u>		9. AGE (In years lost birthday) <u>1</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Alvin E. Fowlkes</u>			14. MOTHER'S MAIDEN NAME <u>Mary Hall</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>                    </u> (If yes, give war or dates of service) <u>                    </u>		16. SOCIAL SECURITY NO. <u>                    </u>		INFORMANT <u>Rosewood Records</u> Address <u>                    </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>491X</u> IMMEDIATE CAUSE (a) <u>Acute and chronic broncho-pneumonia, bilateral</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>                    </u> (c) <u>                    </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mongolism</u>					INTERVAL BETWEEN ONSET AND DEATH <u>                    </u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>                    </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>                    </u> p. m. <u>                    </u> 19 <u>                    </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>                    </u>	20f. (City or town) <u>                    </u> (County) <u>                    </u> (State) <u>                    </u>
21. I certify that I attended the deceased from <u>                    </u> , 19 <u>                    </u> , to <u>                    </u> , 19 <u>                    </u> , that I last saw the deceased alive on <u>                    </u> , 19 <u>                    </u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Ed W. Rieckert</u>		ADDRESS (Street, city or town, state) <u>4307 Mainfield Ave Baltimore 14, Md</u>		DATE SIGNED <u>8-10-60</u>	
PHYSICIAN'S NAME (Type) <u>Ed W. Rieckert</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 20 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosewood</u>	
22d. LOCATION (City, town, or county) <u>Cwings Mills Md</u>		(State) <u>                    </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Elmer Sons</u>		ADDRESS <u>Rustington Md</u>		24a. REC'D BY REGISTRAR <u>                    </u> 24b. REGISTRAR'S SIGNATURE <u>                    </u>	
				DATE <u>APR 21 '60</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

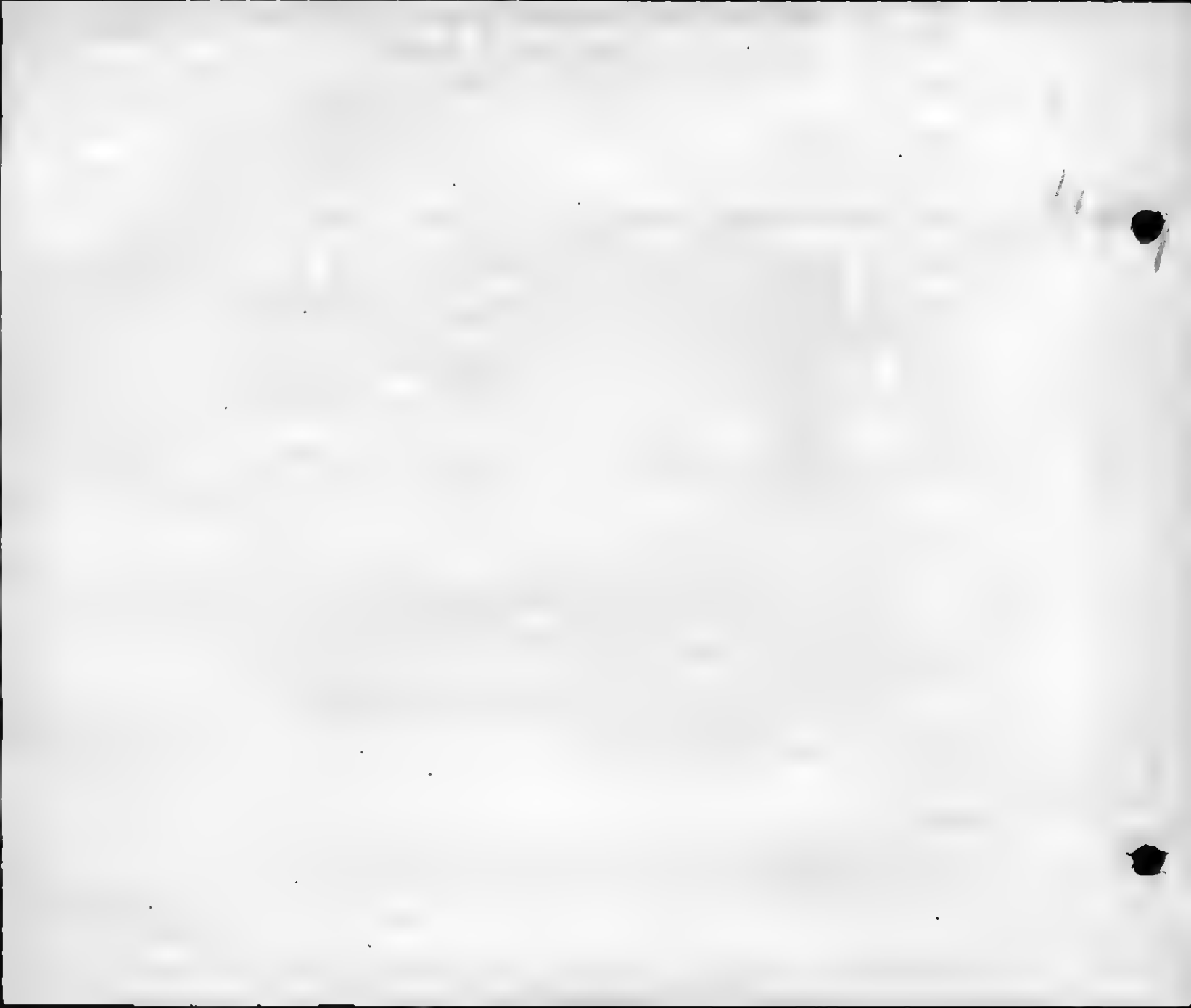
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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Belvoir Road Box 685</u>		d. STREET ADDRESS <u>Belvoir Road Box 685</u>	
3. NAME OF DECEASED (Type or print) First <u>Dixie</u> Middle <u>Gertrude</u> Last <u>Francis</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15-1891</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when retired) <u>School Cafeteria</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward E. M. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Emmie Laurie Stomback</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-30-6070</u>	
17. INFORMANT <u>K. C. Francis</u>		Address <u>Kingville Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Nephrosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 1957, to <u>April</u> , 1960, that I last saw the deceased alive on <u>April 4</u> , 1960, and that death occurred at <u>4 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Tyson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>4-14-60</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>April 16-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Belvoir Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Belvoir Road Box 685</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Surgee Funeral Home</u> ADDRESS <u>3631 Falls Road</u>		24a. REC'D BY REGISTRAR <u>APR 18 '60</u>	24b. REGISTRAR'S SIGNATURE <u>William C. Tyson</u>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

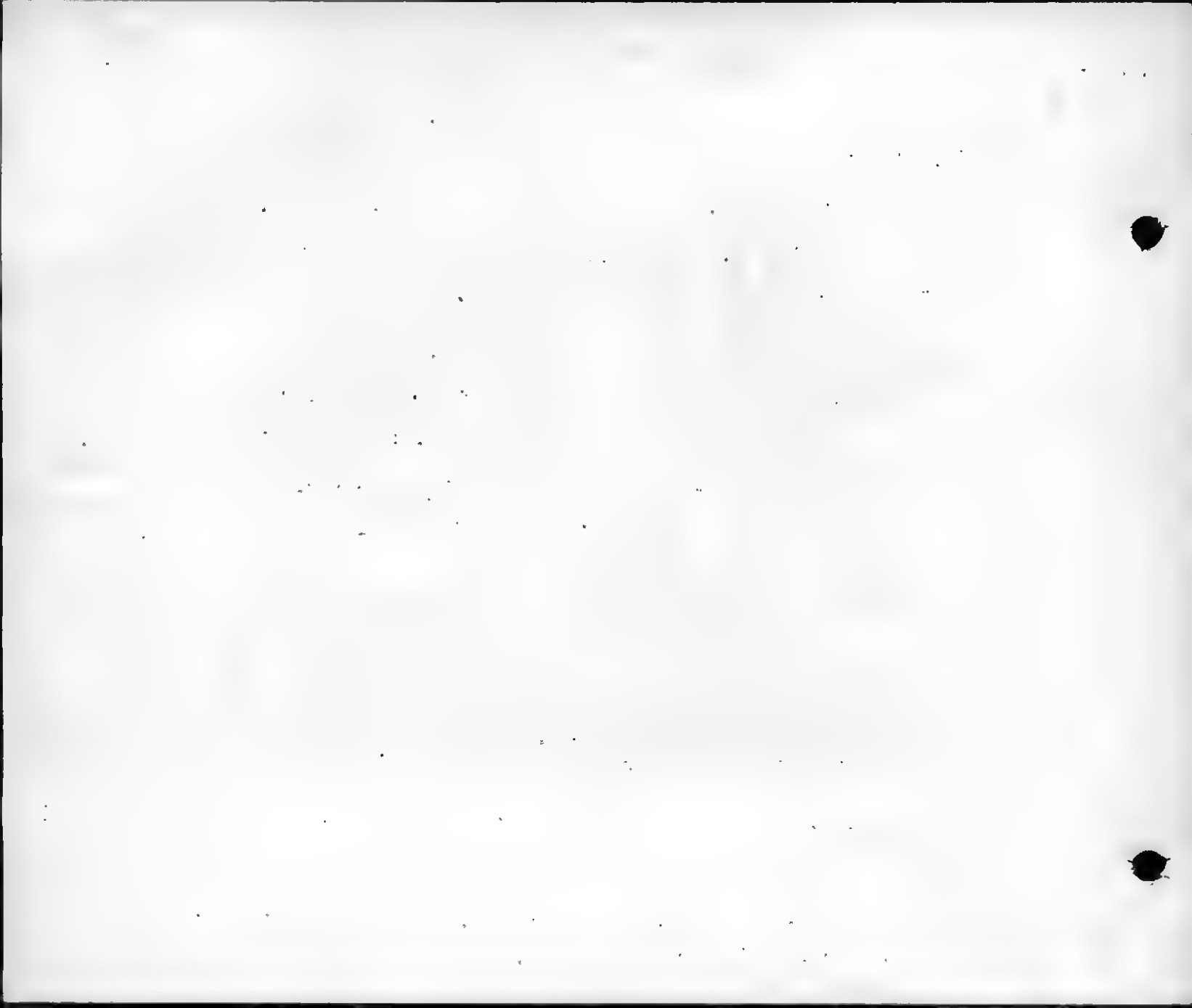
## 4224 CERTIFICATE OF DEATH

b4205  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Halethorpe</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1717 Park Ave.</b>		d. STREET ADDRESS <b>1717 Park Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>E.</b> Last <b>Gartrell</b>		4. DATE OF DEATH Month <b>4</b> Day <b>15</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/29/1882</b>
9. AGE (In years lost birthday) <b>78</b> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alois Schaar</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Rimbach</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>Charles L. Gartrell</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease 2 Yrs</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 8, 1960</b> to <b>April 15, 1960</b> , that I last saw the deceased alive on <b>April 15, 1960</b> , and that death occurred at <b>11:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. Bracey Laugharity</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>4-15-60</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/18/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		24a. REC'D BY REGISTRAR DATE <b>APR 19 '60</b>	
ADDRESS <b>4107 Wilkens Ave.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

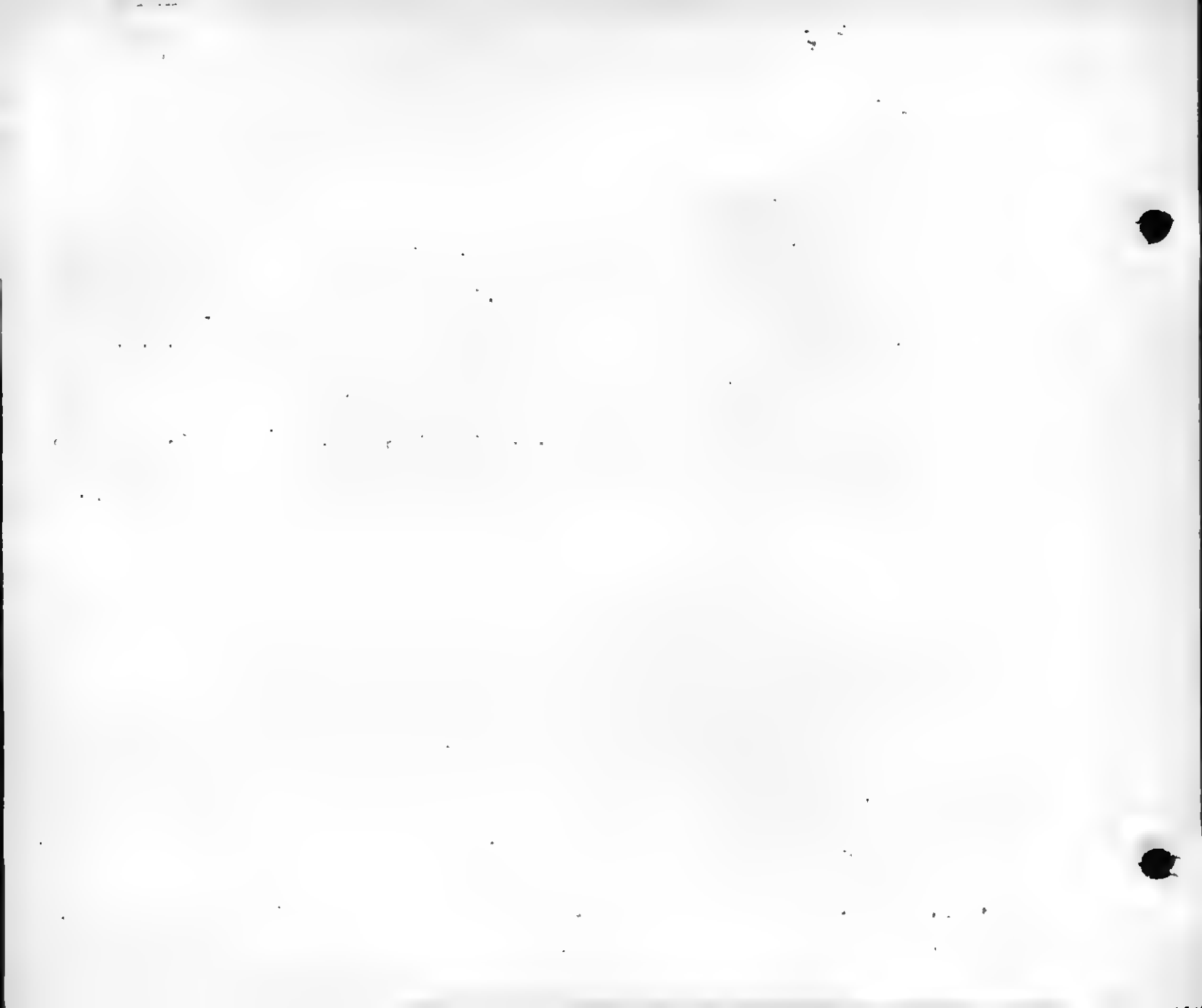
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4274

## CERTIFICATE OF DEATH

64206  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>		c. LENGTH OF STAY IN 1b <b>Baltimore 18</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mercy Villa Bellona Avenue</b>		d. STREET ADDRESS <b>Homewood Apartments</b>	
3. NAME OF DECEASED (Type or print) First <b>Carlotta</b> Middle <b>B</b> Last <b>Geoghegan</b>		4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>1960</b>	
5 SEX <b>FEMAL</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22, 1880</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR: Months <b>7</b> Days <b>19</b> Hours <b>00</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Brady</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Ann Printy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>213-09-5671</b>	
INFORMANT <b>Wm. C. Geoghegan, Cambria Farms Rd., Phoenix, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma sigmoid colon.</b> 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 1948</b> to <b>April 22, 1960</b> , that I last saw the deceased alive on <b>April 22, 1960</b> , and that death occurred at <b>1:10 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stephen J Van Hill</b>		ADDRESS (Street, city or town, state) <b>3001 Greenway Drive</b>	
PHYSICIAN'S NAME (Type) <b>Stephen J Van Hill M.D.</b>		DATE SIGNED <b>4-22-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-25-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Towson, Inc., 1050 York Road, Towson</b>		24a. REC'D BY REGISTRAR DATE <b>APR 25 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



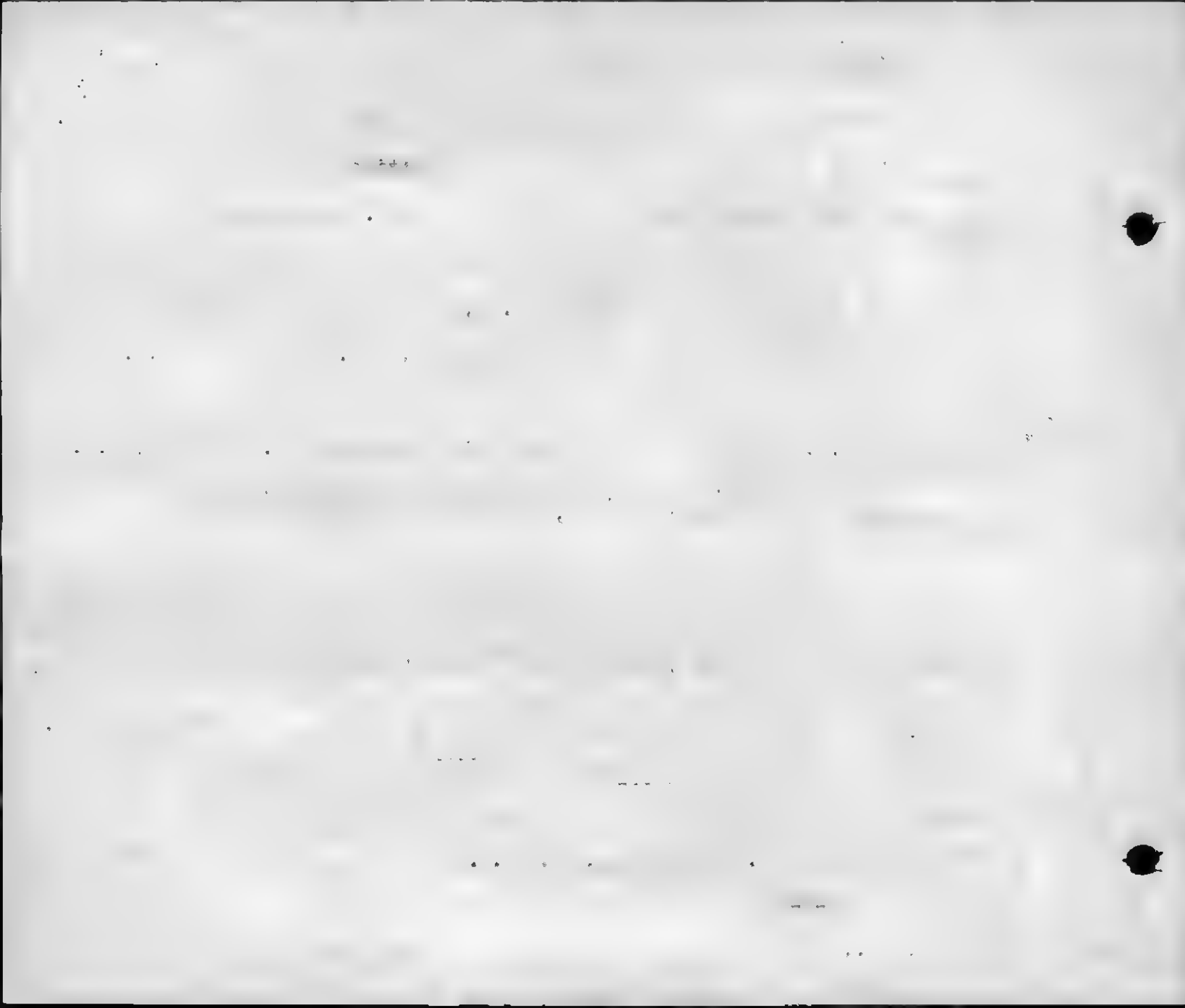
# 1 FOR STATE HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Item 18 Film 263 5-24-60											
MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4216 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 4207											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 18</b> 3101.4					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Bear Creek Bridge</b>						d. STREET ADDRESS <b>301 E. 29th Street</b>					
3. NAME OF DECEASED (Type or print) <b>JERRY G GILL</b>						4. DATE OF DEATH <b>April 29 1960</b>					
5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b>						7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>Feb. 26, 1936</b>					
9. AGE (In years last birthday) <b>24</b> yrs.						10. AGE (In years last birthday) <b>24</b> yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>					
11. BIRTHPLACE (State or foreign country) <b>Milford, Conn.</b>						12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Nathaniel Gill (deceased)</b>						14. MOTHER'S MAIDEN NAME <b>Doris McKean</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES W.W.II</b>						16. SOCIAL SECURITY NO.					
17. INFORMANT <b>Doris Gill, 142 State St., Brockport, N.Y.</b>						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Crushing injury of right chest and blunt-force injury of head, with depressed skull fracture</b>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Asphyxia due to drowning</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Crushing injury of right chest and blunt-force injury of head, with depressed skull fracture.</b>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Apparently knocked off painter's scaffold by moving bridge span</b>											
20c. TIME OF INJURY Month, Day, Year <b>4/29/60</b> 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <b>Bridge</b>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Baltimore Md.</b>											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>W. Bradley King, Jr.</b>											
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b> 22b. DATE THEREOF <b>5-2-60</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Lakeview Cemetery</b> 22d. LOCATION (City, town, or country) (State) <b>Sweeton, New York</b>											
23. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook, Inc., 1217 St. Paul Street</b>											
24a. REC'D BY REG. STRAR <b>MAY 3 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>											

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4275 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

44208  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balti.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balti.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville Md 6 yrs.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pikesville 8</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7500 Richridge Rd</u>				d. STREET ADDRESS <u>7500 Richridge Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA SEIDMAN GOLDSTEIN</u>				4. DATE OF DEATH Month Day Year <u>Apr 6 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 22, 1900</u>	
9. AGE (In years last birthday) <u>60 yrs.</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Seidman</u>				14. MOTHER'S MAIDEN NAME <u>Mary?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Oscar Goldstein - 7500 Richridge Rd Pikesville 8</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>None</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>D. D. Caples</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>D. D. CAPLES</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-8-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Kewin</u>				ADDRESS <u>2100 Eutaw Place</u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any fee is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4276

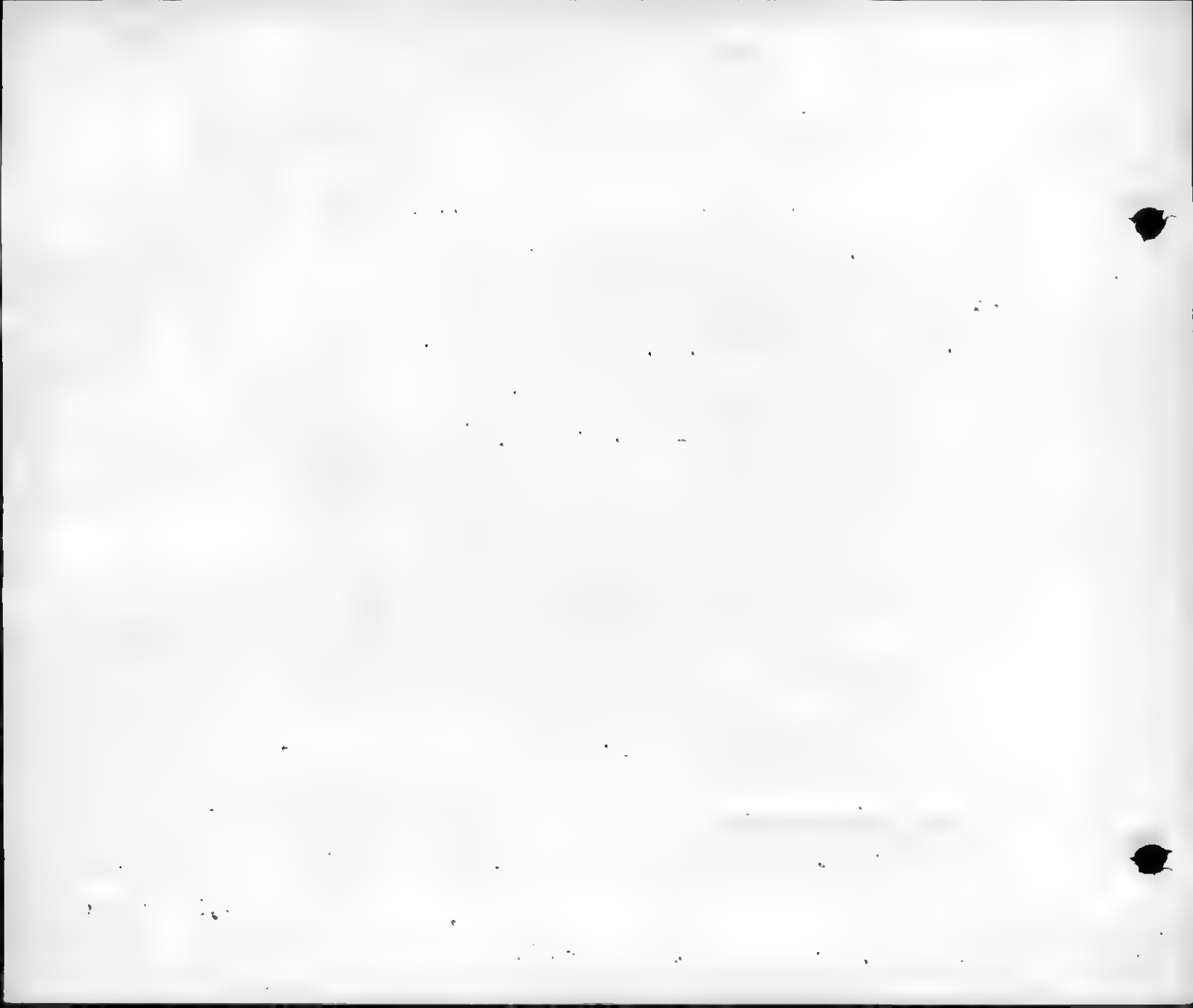
Item 13 File G261 4/25/60 cap

## CERTIFICATE OF DEATH

64209  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2733 Glendale Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr. Vinson</u> First <u>James</u> Middle <u>Gordon</u> Last		4. DATE OF DEATH <u>April 15th</u> 19 <u>60</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1905</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief of Records</u>	11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Jennings Gordon</u>	
14. MOTHER'S MAIDEN NAME <u>Martha Cruikshank</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>206-20-7427</u>		17. INFORMANT <u>Mrs. Geneva Gordon</u> Address <u>2733 Glendale Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Branchogenic Carcinoma</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>14 MO.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>2/21/59</u> 19____ to <u>4/15/60</u> 19____, that I last saw the deceased alive on <u>4/14/60</u> 19____, and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold A. Grott</u> M.D. <u>8100 Harford Rd</u>		DATE SIGNED <u>4/16/60</u>	
PHYSICIAN'S NAME (Type) <u>HAROLD A. GROTT, M.D.</u>		<u>BALTO-14, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/19/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>APR 19 60</u>	24b. REGISTRAR'S SIGNATURE <u>Clara J. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4277

Items 8, 9 Film 6260 4-8-60 et

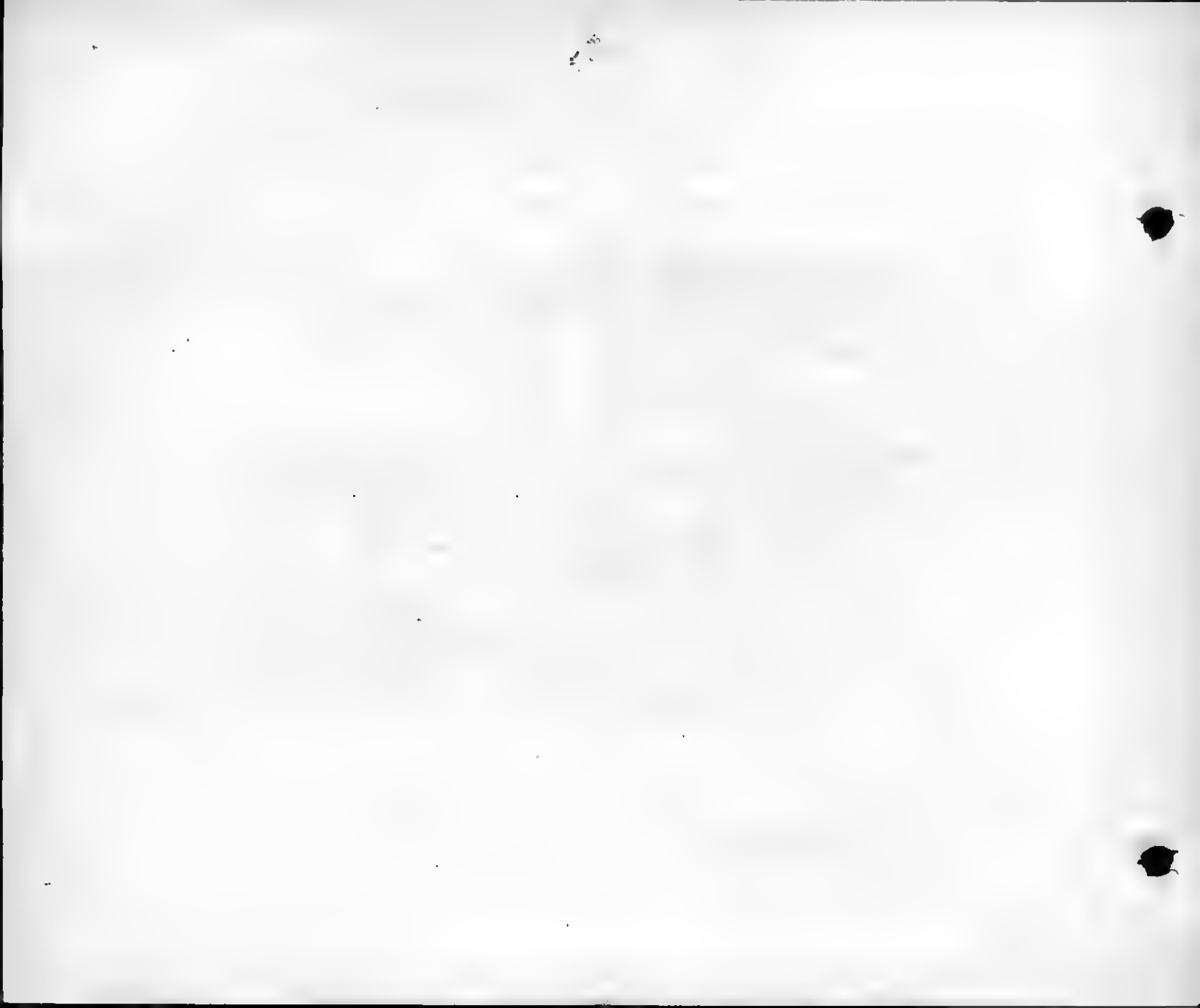
## CERTIFICATE OF DEATH

64210

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4503 Kenwood Ave.</b>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b> d. STREET ADDRESS <b>4503 Kenwood Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Robert Fulton Groshans</b> First Middle Last 4. DATE OF DEATH <b>April 2 1960</b> Month Day Year		5. SEX <b>male</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>June 24 1897</b> 9. AGE (in years last birthday) <b>62</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clothing cutter</b> 11. BIRTHPLACE (State or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Groshans</b> 14. MOTHER'S MAIDEN NAME <b>Sophis Fauler</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> 16. SOCIAL SECURITY NO. <b>Informant</b> Address <b>Mrs Helen Groshans 4503 Kenwood Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> - 120.1 DUE TO <b>Coronary Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Insufficiency</b> DUE TO <b>old posterior Myocardial Infarction</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Heart block - arrhythmia</b>		INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>March 27 1960</b> to <b>April 12 1960</b> that I last saw the deceased alive on <b>April 2 1960</b> and that death occurred at <b>345 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>3001 Shandon Drive Baltimore Md.</b> DATE SIGNED <b>April 13 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b> 22b. DATE THEREOF <b>April 5/60</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b> 22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 4210 Belair Road</b> 24a. REC'D BY REGISTRAR <b>APR 5 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

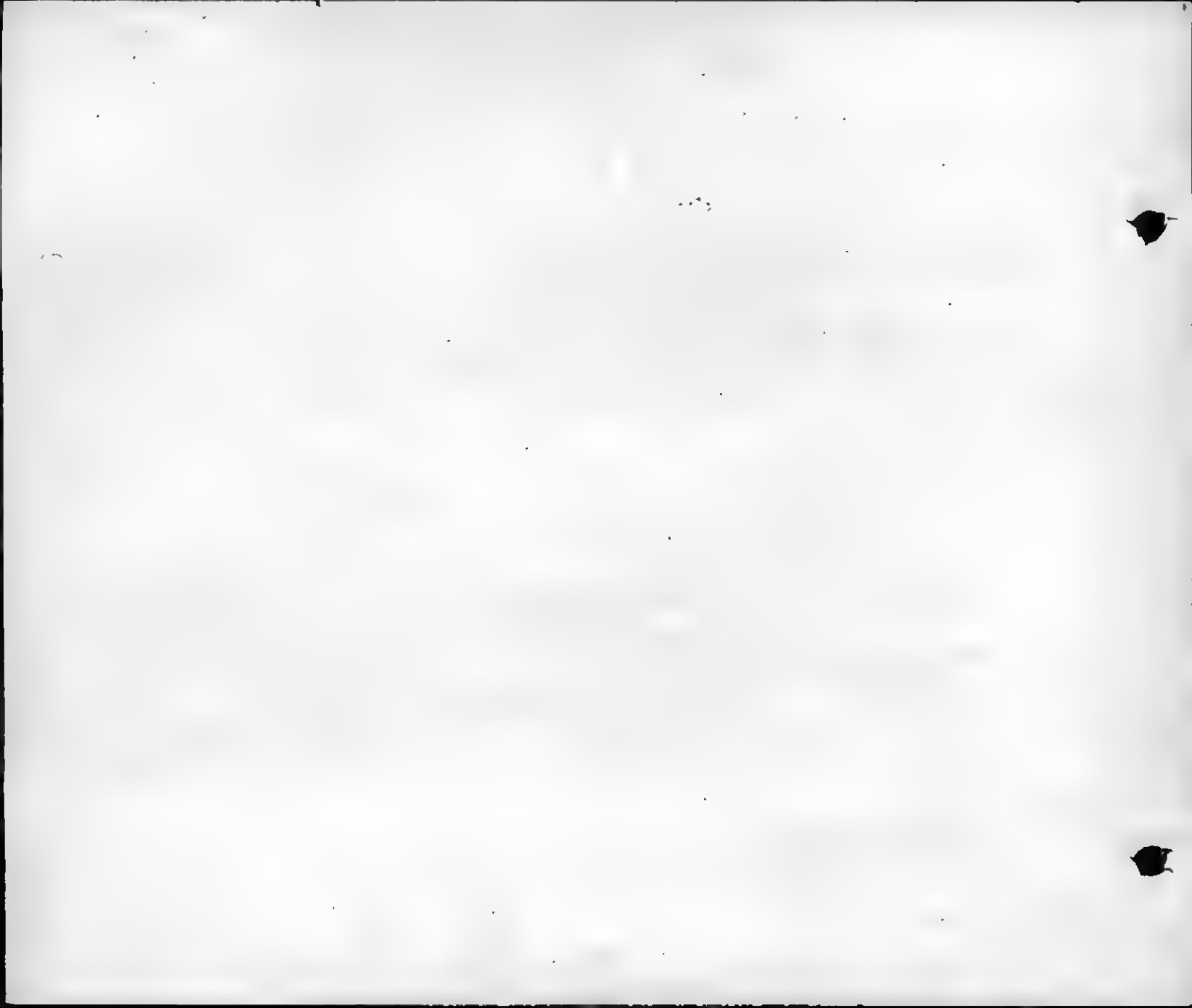


may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4278 CERTIFICATE OF DEATH

04211

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>BALTIMORE</b>				c. LENGTH OF STAY IN 1b <b>10 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>17818 RIVERDALE AVE.</b>				d. STREET ADDRESS <b>17818 RIVERDALE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>C. CHARLOTTE C. GROVES</b> First Middle Last				4. DATE OF DEATH <b>APRIL 7 1960</b> Month Day Year			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 12, 1897</b>	
				9. AGE (In years last birthday) <b>62</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>FRANK WISNIEWSKI</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <b>7818 Riverdale Ave.</b>			
17. INFORMANT <b>Wm. J. Davis</b> Address <b>7818 Riverdale Ave.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>multiple sclerosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from _____ 1958, to <b>April 7, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 7, 1960</b> , and that death occurred at <b>12 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Emmett P. Davis</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) <b>EMMETT P. DAVIS</b>				22d. ADDRESS <b>5317 BELAIR Rd BALTO MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/11/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ONK LAWN. CEM.</b>		23d. LOCATION (City, town or county) <b>BALTO, MD.</b> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry Miller</b> ADDRESS <b>2334 Jefferson St.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 8 '60</b>		25b. REGISTRAR'S SIGNATURE <b>C. H. H. H.</b>	



4279

CERTIFICATE OF DEATH

04212  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lansdowne 27</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Nursing Home</b>		d. STREET ADDRESS <b>12 Third Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Gunther</b> Last <b>Gunther</b>		4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 9, 1879</b>
9. AGE (In years last birthday) <b>80</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>9</b> Hours <b>14</b> Min <b>00</b>	11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(ret'd) Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Garment Factory</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>(unknown) Gunther</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Francis P. Saunders</b>		Address <b>1707 Spring Rd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>598.0</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>598.0</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 1, 1960</b> to <b>April 14, 1960</b> , that I last saw the deceased alive on <b>April 12, 1960</b> , and that death occurred at <b>5 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Morris W. Steinberg</b> M.D.		ADDRESS (Street, city or town, state) <b>3913 Hollins Ferry Road</b> DATE SIGNED <b>4/14/60</b>	
PHYSICIAN'S NAME (Type) <b>Morris W. Steinberg</b>		<b>3913 Hollins Ferry Road</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4-16-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>4430 Belair Road</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR <b>APR 18 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0251

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64213

Reg. Dist. No.

4280

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MIDDLE RIVER</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>49 FOXGLOVE LANE #20 MD</b>		e. STREET ADDRESS <b>49 FOXGLOVE LANE #20 MD</b>	
3. NAME OF DECEASED (Type or print) <b>MARGUERITE</b>		4. DATE OF DEATH <b>APRIL 22 1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 3, 1902</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR: Months <b>22</b> Days <b>22</b> Hours <b>22</b> Min. <b>22</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COOK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COTTAGE INN</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE TAYLOR</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN GREEN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO <b>120-24-6516</b>	
17. INFORMANT <b>VALLORIE CLARK</b>		Address <b>49 FOXGLOVE LANE #20</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive C-V Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>None</b> (c) <b>None</b> DUE TO Cause lost (c) <b>None</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M B Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M B DAVIS MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>APRIL 25, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>CHASE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jesseln Funeral Home 7401 Belair Rd. #6</b>		24a. REC'D BY REGISTRAR <b>DATE APR 27 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a temporary certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





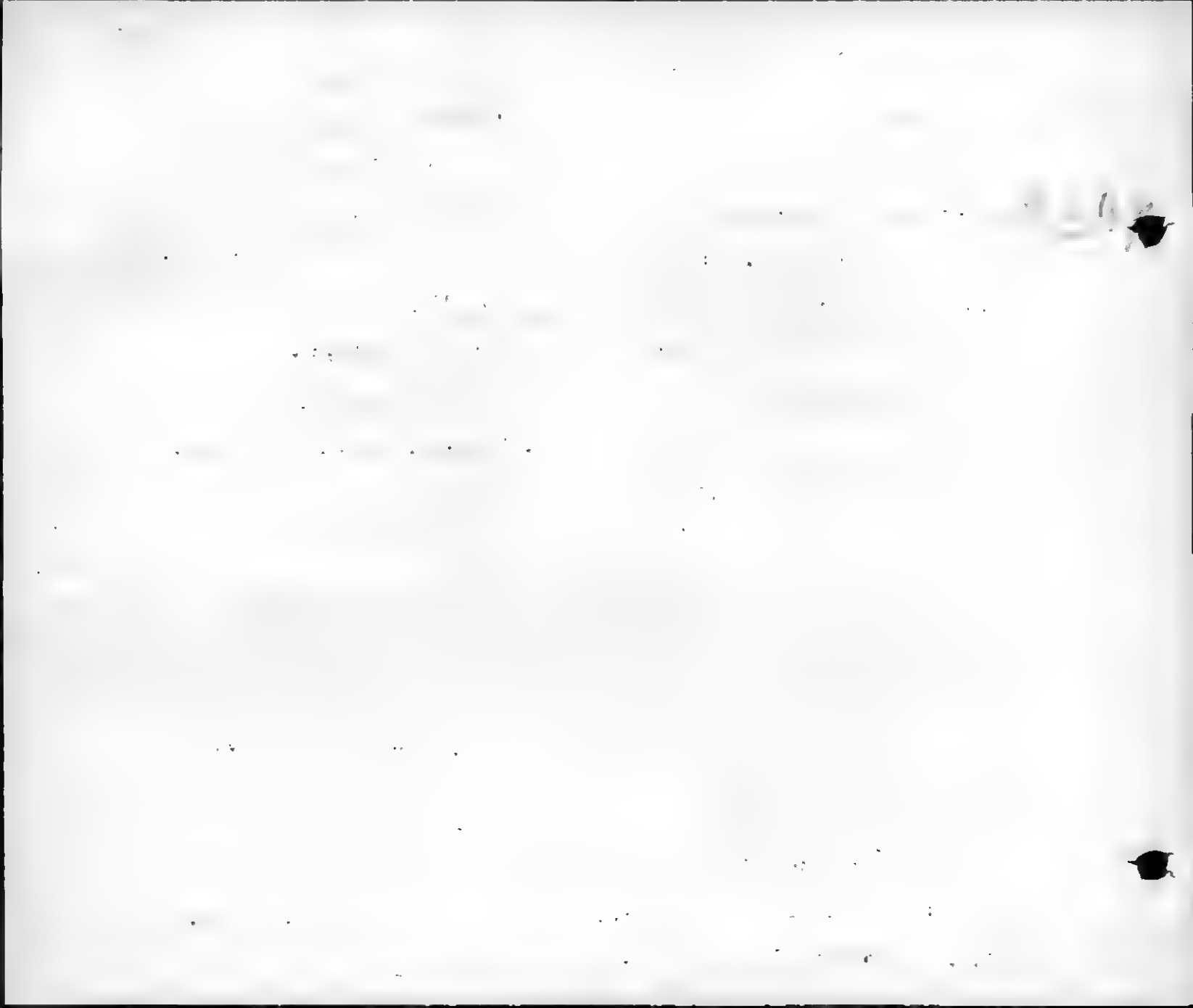
## 4281 CERTIFICATE OF DEATH

64214  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>17x</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> d. STREET ADDRESS <b>434 Columbia Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELEANOR F. HARDY</b>		4. DATE OF DEATH Month Day Year <b>April 12, 1960 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 31, 1875</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Howard County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Randolph Day</b>		14. MOTHER'S MAIDEN NAME <b>Alberta Warfield</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Charles R. Slade, Ellicott City, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CVA</b> DUE TO (c) <b>ASCVD</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 Wks</b> <b>10 Yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-5</b> , 19 <b>58</b> to <b>4-12</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4-12</b> , 19 <b>60</b> , and that death occurred at <b>4 P M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>PV Thorpe</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>409 Columbia Road Ellicott City, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Peter Van B Thorpe, M.D.</b>		<b>Ellicott City, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-15-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Damascus Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>Damascus, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 18 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4282 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04215

Reg. Dist. No.

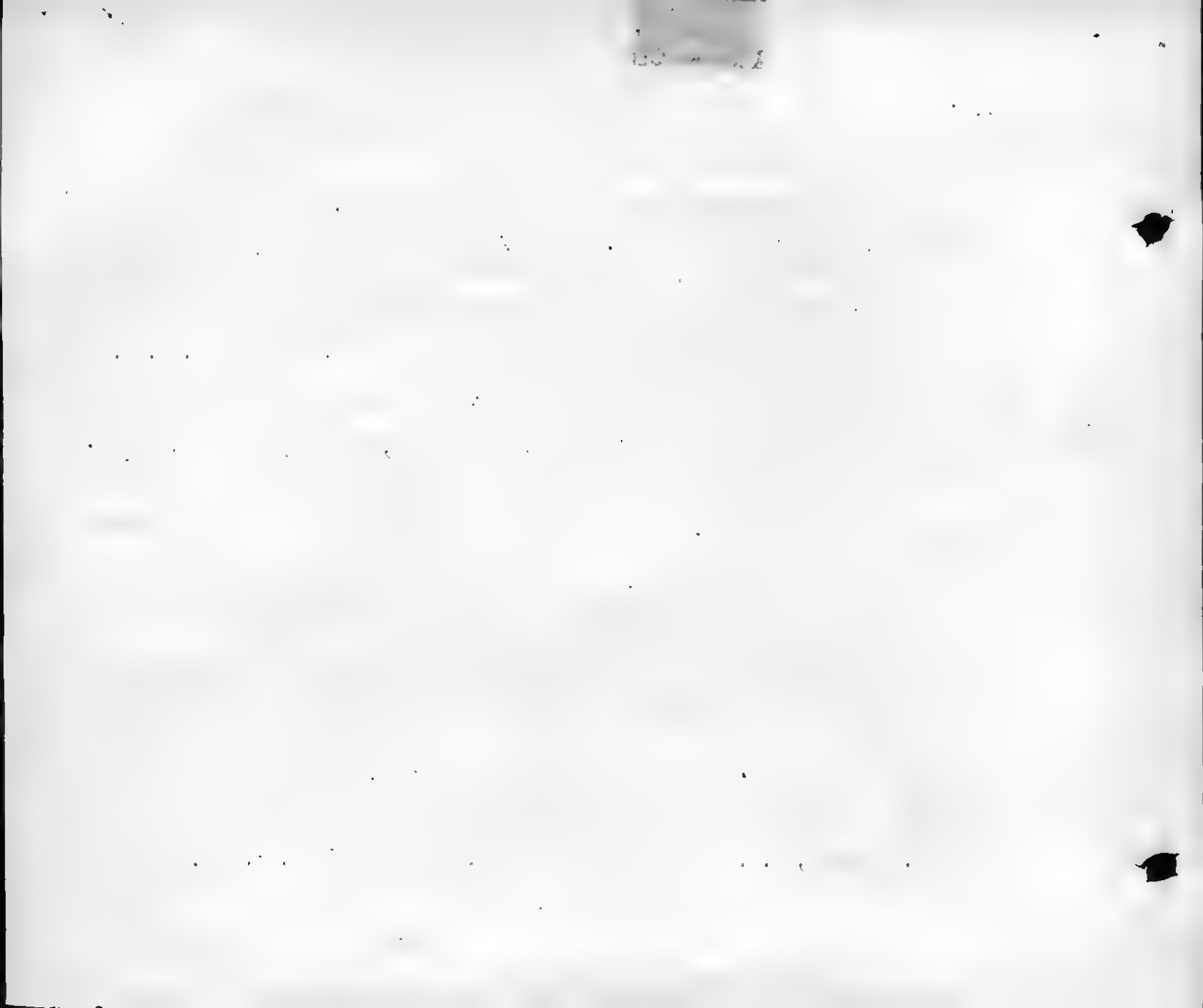
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. LENGTH OF STAY IN 1b <u>4 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1701 Reisterstown Road</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Wesley</u> Last <u>Wart</u>		4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 12, 1948</u>
9. AGE (In years last birthday) <u>12</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pikesville, South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leon Eugene Wart</u>		14. MOTHER'S MAIDEN NAME <u>Ida Pearl Wart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>1-000-000000</u>	
17. INFORMANT <u>Dr. D. D. Caples, 1701 Reisterstown Rd., Baltimore, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound Fracture of skull (multiple)</u> 812.X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ none 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Riding bicycle S. on Reist. Rd., fell off &amp; was struck by auto.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>4:25</u> p.m. <u>Apr. 12 1960</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Reist. Rd.</u>	20f. (City or town) (County) (State) <u>Pikesville Balto. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D. D. Caples</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 15, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>U.S. Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE <u>APR 19 '60</u>	

45

1

## 64216

PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>1</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>5 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		<b>2V.1.4.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>576 Oxford Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Served as <b>GEORGE</b> First Middle Last (Type or print) <b>GEORGE</b> <b>W.</b> <b>HATCHER</b> )				4. DATE OF DEATH Month Day Year <b>April 29 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 4, 1892</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Longshoreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shipping</b>		11. BIRTHPLACE (State or foreign country) <b>Fayetteville, N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Hatcher</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Williams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>WW I 217-01-9910</b>		17. INFORMANT <b>Clin. Records, VAH, Balto. 18, Md. Ft. Howard Division</b>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE HEART FAILURE</b> DUE TO <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) <b>UNKNOWN</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Emphysema</b>						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that <b>11</b> (this hospital) attended the deceased from <b>April 24</b> , 19 <b>60</b> to <b>April 29</b> , 19 <b>60</b> , that <b>1</b> (we) last saw the deceased alive on <b>4/29/60</b> , 19 <b>60</b> , and that death occurred at <b>4:45 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>John D. Talbert, M.D.</b>				22b. ADDRESS <b>VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION</b>		22c. DATE <b>4/29/60</b>	
23a. BURIAL, CREMATION, REINTERMENT (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/3/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Marshall P. Hayes</b>				25a. DATE <b>5/2/60</b>		25b. REG. STRAR'S SIGNATURE <b>Arthur L. Hayes</b>	
25c. ADDRESS <b>Marshall Hayes, 638 N. Gilmor St., Balto. Md.</b>							



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4284

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

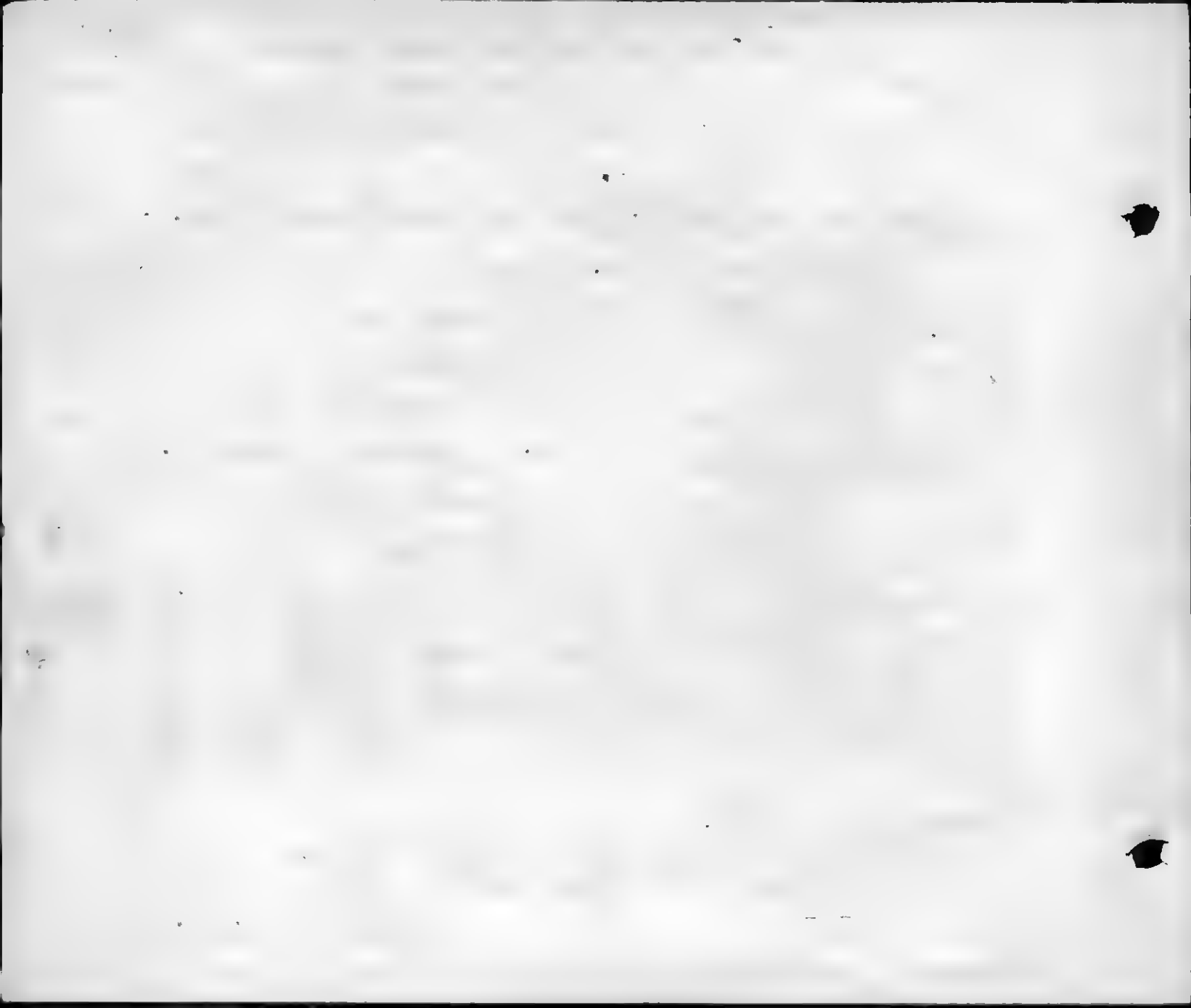
64217

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Marsh</b>				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 145 Bird River Grove Rd.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Marsh</b>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>H.</b> Last <b>Hausler</b>				4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 22, 1895</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months <b>27</b> Days <b>19</b> Hours <b>60</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown Turling</b>				14. MOTHER'S MAIDEN NAME <b>Unknown Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Roy Hausler</b> Address <b>6100 Sefton Ave. 14</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arterio Sclerosis</b> DUE TO (c) <b>Myocardial Infarction</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>24 hrs</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Jack C Collins</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Jack C Collins</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-29-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lorawan Funeral Home</b>				ADDRESS <b>7401 Belair Rd.</b>		24a. REC'D BY REGISTRAR <b>APR 29 1960</b>	
				24b. REGISTRAR'S SIGNATURE <b>John S. Miller</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further action is necessary, please execute it in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 c, Film G261 4/26/60 iwk

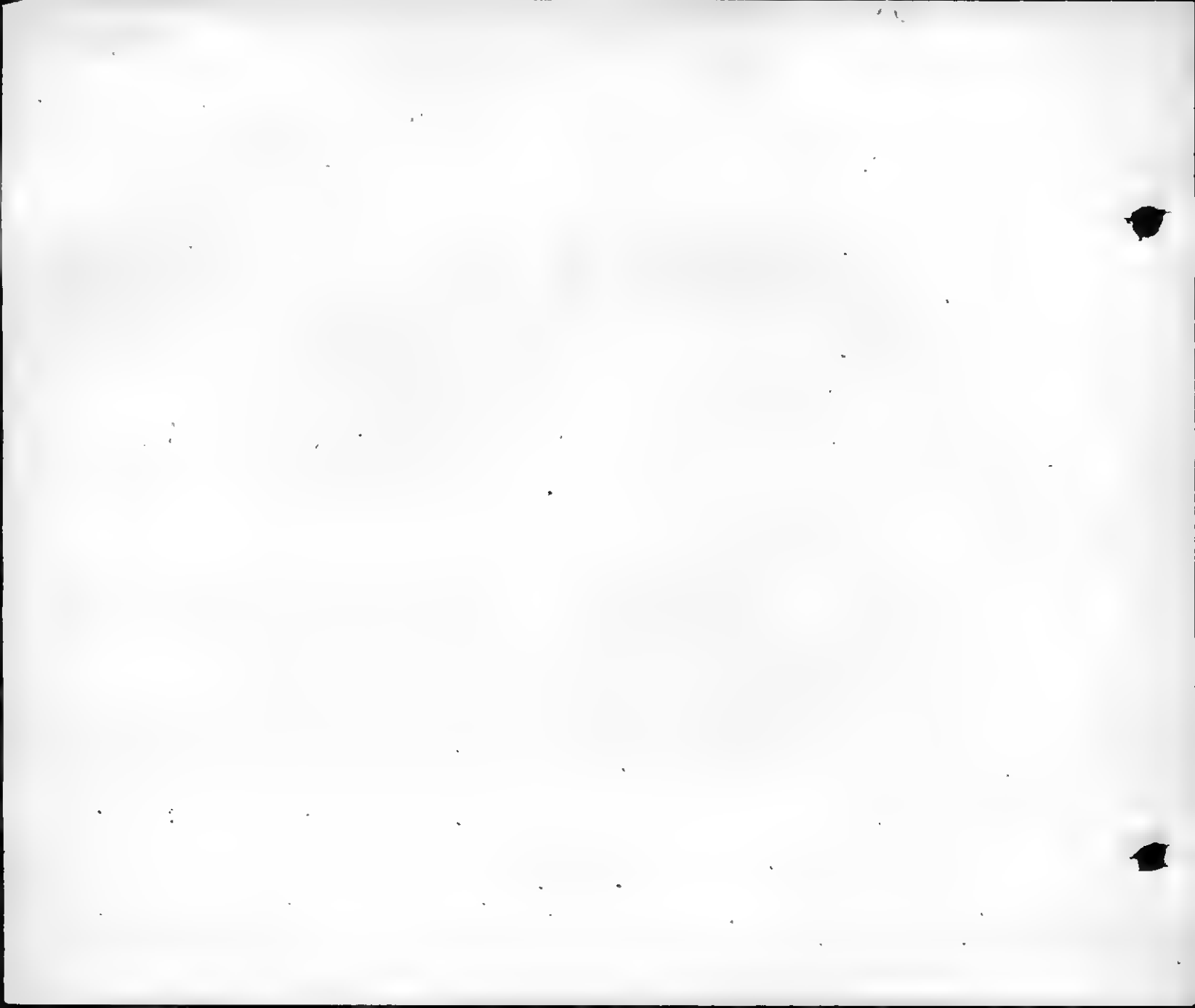
## CERTIFICATE OF DEATH

Reg. Dist. No.

64220

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pikesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Pikesville 8, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Own home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Catherine</b> Middle <b>Williams</b> Last <b>Rein</b>		4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 17, 1868</b>
9. AGE (In years last birthday) <b>91</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Williams</b>		14. MOTHER'S MAIDEN NAME <b>Anna Plock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>r. Paul Rein, 211 Clarendon Ave., Pikesville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>491 X</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SMOKING</b>			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>APRIL 11, 1960</b> to <b>APRIL 13, 1960</b> , that I last saw the deceased alive on <b>APRIL 12, 1960</b> , and that death occurred at <b>12:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Francis T. Daly</b>		ADDRESS (Street, city or town, state) <b>1725 RUSTLETOWN Rd Pikesville 8, Md.</b>	
PHYSICIAN'S NAME (Type) <b>FRANCIS T. DALY</b>		DATE SIGNED <b>4/15/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 16, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lanham Park</b>	22d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell, Pikesville</b>		24a. REC'D BY REGISTRAR <b>APR 19 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



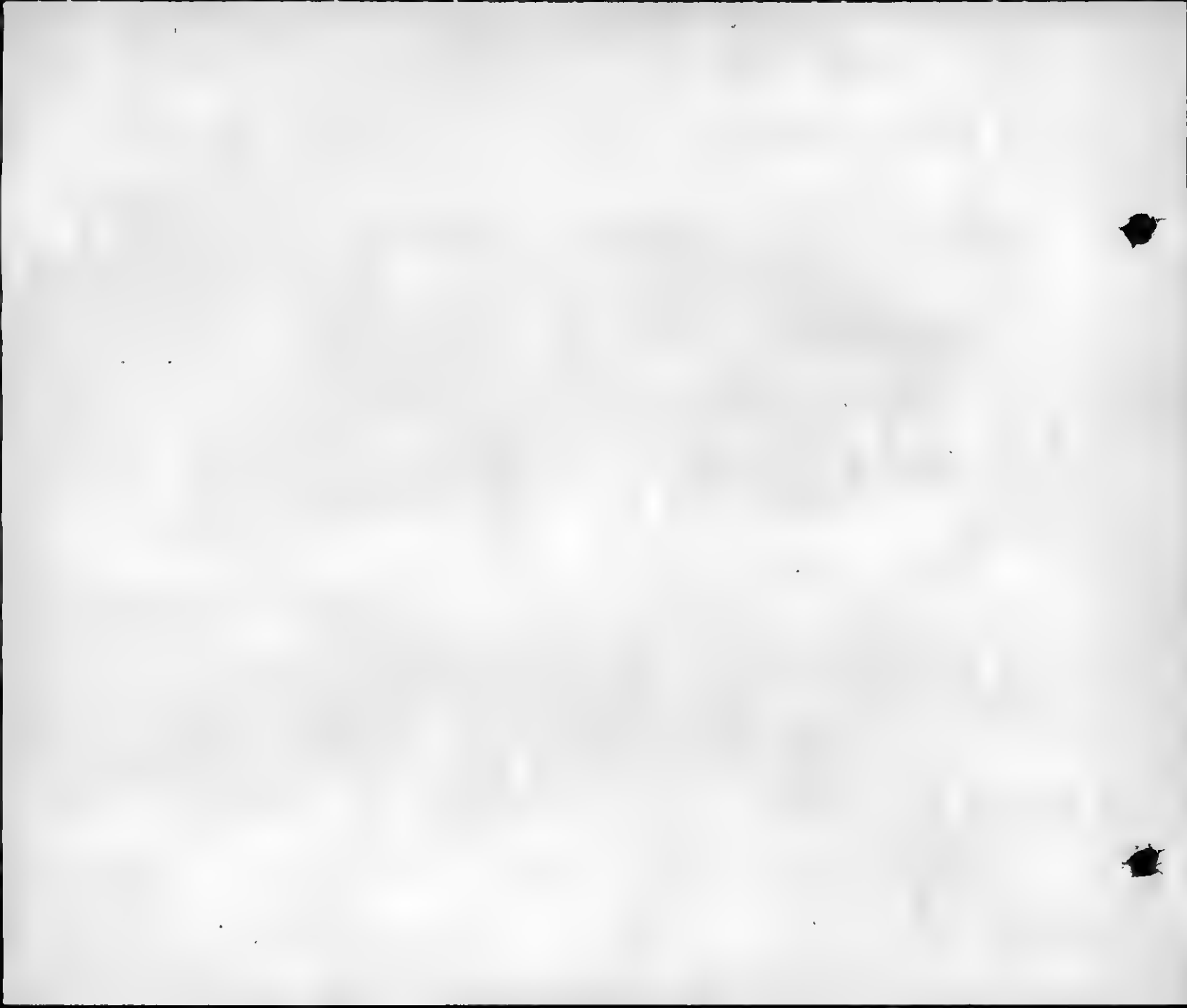
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, marking the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4217 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64221  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dundalk</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Dundalk</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2620 Yorkway</u>				d. STREET ADDRESS <u>2620 Yorkwat</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Miller Henderson VI</u>				4. DATE OF DEATH Month Day Year <u>April 22, 19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 19, 1911</u>		9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert M. Henderson</u>				14. MOTHER'S MAIDEN NAME <u>Lilly Weaver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs. Pauline Henderson 2620 Yorkway</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occ</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>24 hrs</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Ullrich</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Sack P Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 26, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Carlyle, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ullrich Funeral Home Dundalk, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	



4286

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u>		c. LENGTH OF STAY IN 1b <u>X Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ebenezer Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>August</u> Middle <u>Hennlein</u> Last <u>Hennlein</u>		4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22, 1865</u>
9. AGE (In years last birthday) <u>94</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ADAM HENNLEIN</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET LUDWIG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>George W. Hennlein</u>		Address <u>Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gangrene - Peripheral Vascular Disease</u> DUE TO <u>A S C V D</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCLVD</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 1958</u> to <u>April 1, 1960</u> , that I last saw the deceased alive on <u>April 14, 1960</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>4-19-60</u>	
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-22-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Chase, Balto. Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
24a. REC'D BY REGISTRAR <u>APR 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APRIL 11-1944

4.4

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

4218

64223

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1906 Adams Road</b>		d. STREET ADDRESS <b>1906 Adams Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>A.</b> Last <b>HILLEBRAND</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 1, 1921</b>
9. AGE (In years last birthday) <b>39</b> yrs	IF UNDER 1 YEAR Months <b>39</b> Days <b>39</b> Hours <b>39</b> Min <b>39</b>	IF UNDER 24 HRS Months <b>39</b> Days <b>39</b> Hours <b>39</b> Min <b>39</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Janowitz</b>		14. MOTHER'S MAIDEN NAME <b>Mary Kwedar</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO <b>INFORMANT</b> Address <b>Mrs. Mary Janowitz 6609 Pine Ave.</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b>			
DUE TO (b) <b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>			
DUE TO (c) <b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1, 1945</b> to <b>Apr 6, 1960</b> that I last saw the deceased alive on <b>April 1, 1960</b> , and that death occurred at <b>6 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>M. W. Jacobson</b>		ADDRESS (Street, city or town, state) <b>6621 Reisterstown Rd Baltimore, Md.</b>	
PHYSICIAN'S NAME (Type) <b>M. W. Jacobson M.D.</b>		DATE SIGNED <b>4-6-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 8, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Mary</b>		22d. LOCATION (City, town, or county) (State) <b>Dundalk, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home Dundalk, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 11 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>C. L. S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



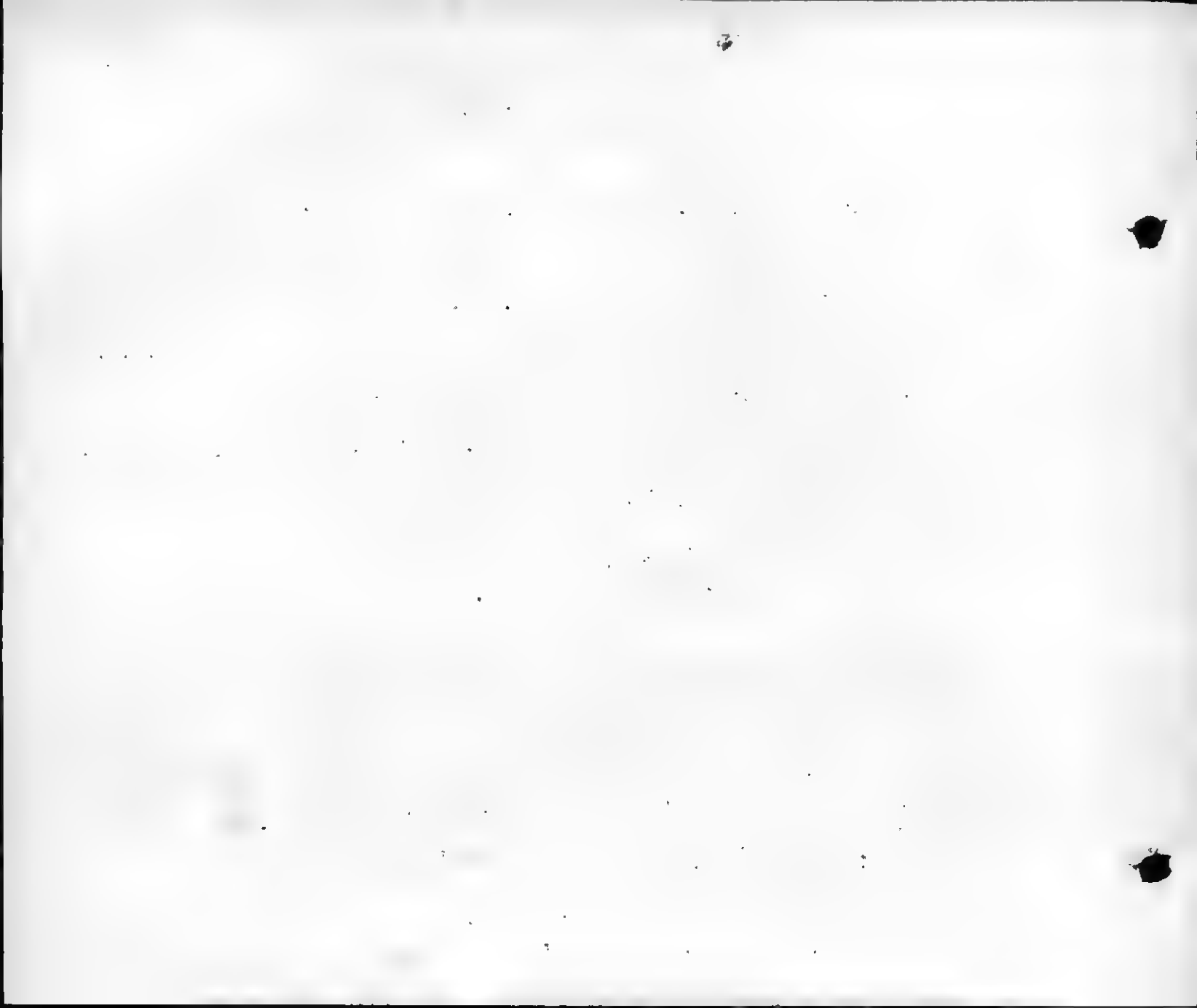


4287

CERTIFICATE OF DEATH

64224  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>16</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The House in The Pines 16 Fustling Avenue</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 30</b> d. STREET ADDRESS <b>2519 Smith Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Georgia</b> Middle <b>N</b> Last <b>Holdson</b>		4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 22, 1889</b>
9. AGE (In years last birthday) <b>71</b>		10. IF UNDER 1 YEAR <b>71</b> IF UNDER 24 HRS <b>71</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireworks Factory</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Nobelte</b>		14. MOTHER'S MAIDEN NAME <b>Anna Storke</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO <b>219-14-3250</b>	
17. INFORMANT <b>George R. Holdson</b>		Address <b>2519 Smith Avenue, Zone 30</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>cerebral hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>hypertension</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-26-58</b> to <b>4-20-60</b> , 19, that I last saw the deceased alive on <b>4-20-60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harry S. Gimmel</b>		M.D. <b>4605 Edmondson</b> DATE <b>4-21-60</b>	
PHYSICIAN'S NAME (Type) <b>HARRY S. GIMBEL</b>		4605 Edmondson Avenue	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-23-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William C. Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR <b>APR 25 '60</b>	
24b. REGISTRAR'S SIGNATURE			



4288

## CERTIFICATE OF DEATH

64225  
Reg. Dist. No.

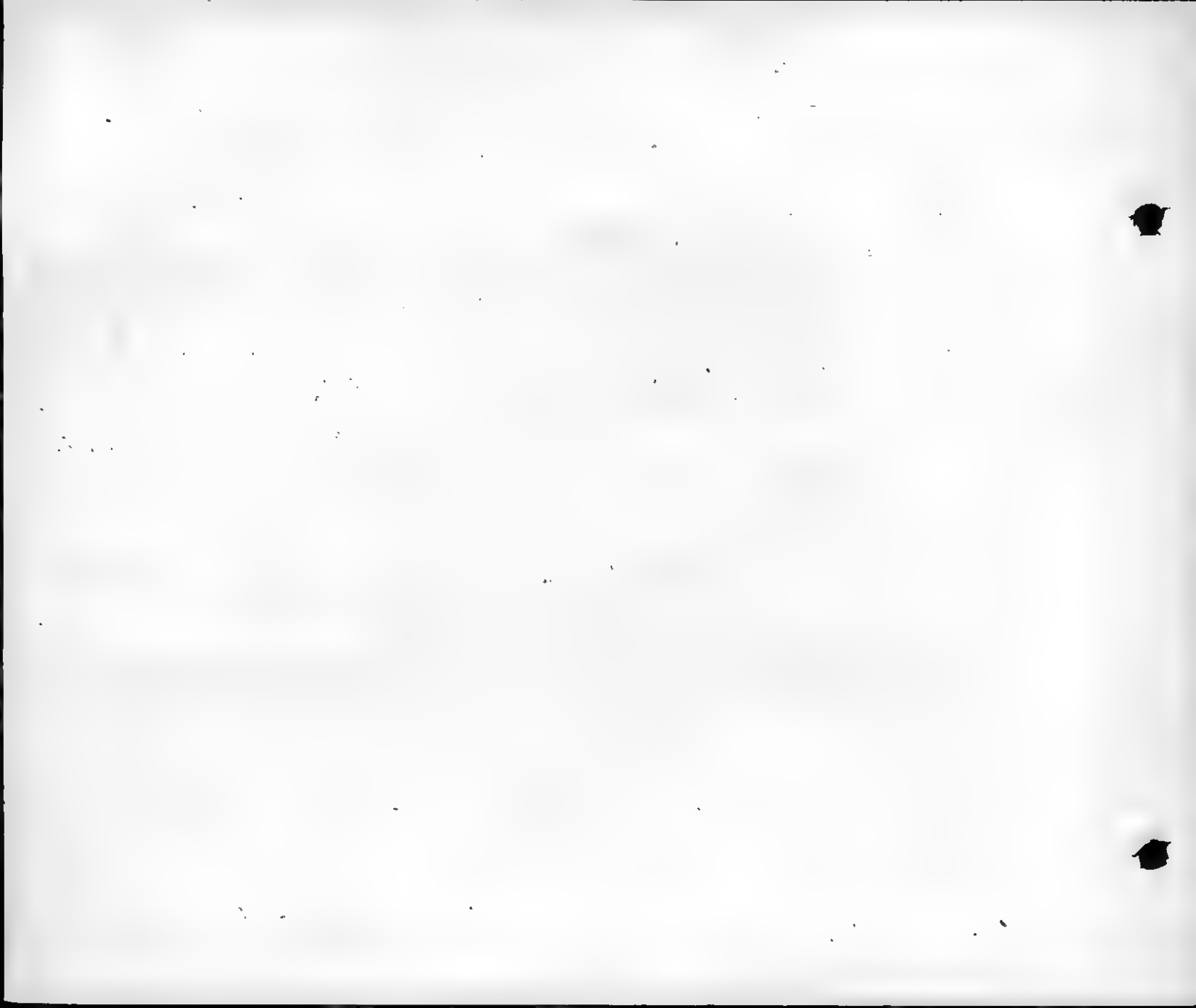
1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. LENGTH OF STAY IN TB <u>8 yrs.</u> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex (21)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1603 Gail Rd.</u>		e. STREET ADDRESS <u>1603 Gail Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JANNIE M. HOLLER</u>		4. DATE OF DEATH <u>APR. 3 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 1 - 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Safius Setzler</u>		14. MOTHER'S MAIDEN NAME <u>Nora Nelson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>Marvin A. Holler</u> INFORMANT Address <u>(Same)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Pneumonitis</u> DUE TO (c) <u>Multiple metastatic carcinomas</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>8 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1960</u> to <u>April 2, 1960</u> that I last saw the deceased alive on <u>April 2 1960</u> and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Little</u>		ADDRESS (Street, city or town, state) <u>1515 Martin Blvd, Balt 20124</u> DATE SIGNED <u>4-4-60</u>	
PHYSICIAN'S NAME (Type) <u>John G. Connolly - Essex Md.</u>		22a. REC'D BY REGISTRAR DATE <u>APR 6 '60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>4-4-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GREEN LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>Belmont N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly - Essex Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
TSM 9/58



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4289 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

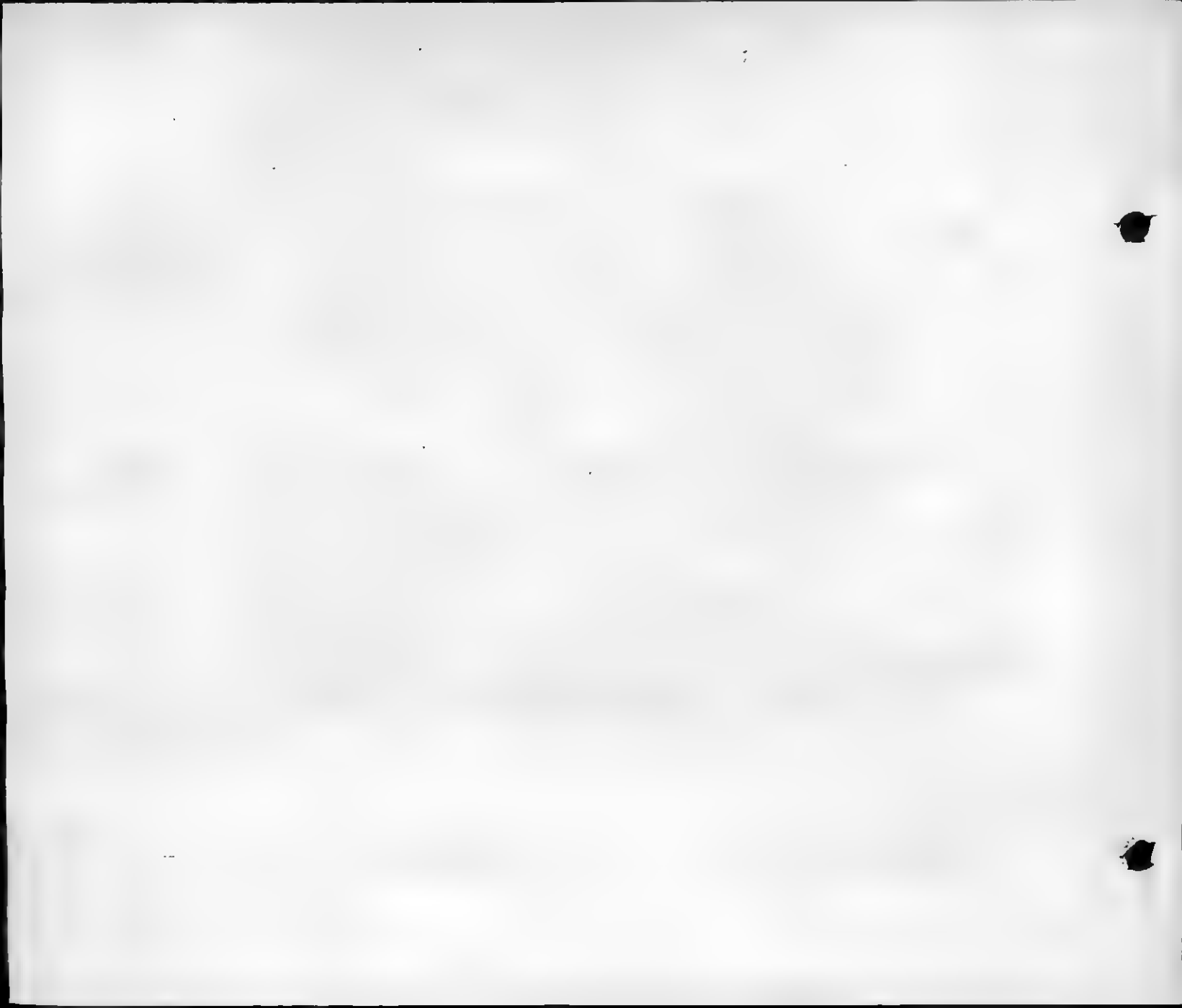
Reg. Dist. No.

64226

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore--rural</b> c. LENGTH OF STAY IN 1b <b>1 1/2 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Balto</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore--rural--Parkville</b> d. STREET ADDRESS <b>2905 Second Ave</b> e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Antonia A Horecka</b>		4. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>28 April 1889</b> 9. AGE (In years last birthday) <b>70</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Kratochill</b>		14. MOTHER'S MAIDEN NAME <b>Don't know</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Josephine Stronsky (daughter) same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardio Vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>Diabetes Mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>undet</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)	
20g. (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>John C. Hyle</b> EXAMINER'S NAME (Type) <b>John C Hyle MD</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>4-8-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		22b. DATE THEREOF <b>April 9/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Blanford Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Petersburg Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 4210 Belair Road</b>		24a. REC'D BY REGISTRAR DATE <b>APR 11 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>C. L. Kraus</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health. its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4290

**CERTIFICATE OF DEATH**

64227

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>East</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u>				c. LENGTH OF STAY IN 1b <u>6 MONTHS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DIASCNIC HOME</u>				d. STREET ADDRESS <u>13605 DUXLEY LANE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FLORA</u> Middle <u>HUBER</u> Last <u>HUBER</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>19</u> Year <u>1966</u>			
5. SEX <u>FE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-1-1866</u>	
9. AGE (In years last birthday) <u>93</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PENNA.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>GILMER HULL</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA MCCARRER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NINE</u>		17. INFORMANT <u>Frank X Smith, 1217 St. Paul St., Baltimore, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Cardio</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Vascular Disease</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o <u>  </u> m <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>		(County) <u>  </u>		(State) <u>  </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>10-14</u> 19 <u>63</u> to <u>4-18</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4-12</u> 19 <u>66</u> , and that death occurred at <u>1:25</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Walter T. Kees</u>				22b. DATE SIGNED <u>4/9/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>WALTER T. KEES</u>				22d. ADDRESS <u>1217 St. Paul St.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-22-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Columbia, Pennsylvania</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				25a. REC'D BY REGISTRAR DATE <u>APR 21 '60</u>		25b. REGISTRAR'S SIGNATURE <u>  </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

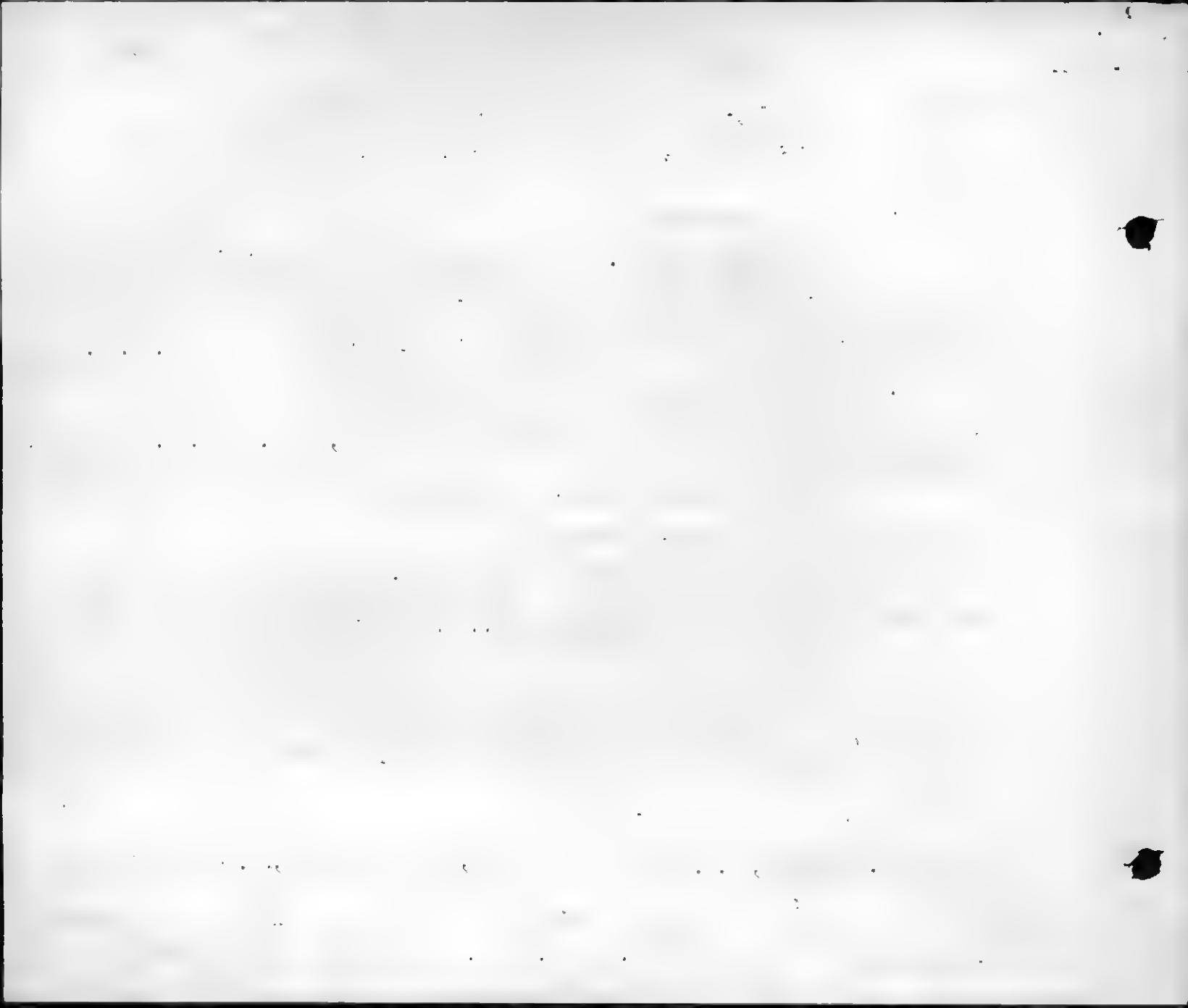
**4291 CERTIFICATE OF DEATH**

64228

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. LENGTH OF STAY IN 1b <b>18 Days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (29)</b> X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>5423 Channing Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>ROLAND</b>		First <b>A.</b> Middle <b>HYLAND</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 4, 1887</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William A. Hyland</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Hardy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO		17. INFORMANT Address <b>Clinical Records VAH, Balto. 18, Md. Ft. Howard Div.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>491X</b> <b>CEREBRAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>ARTERIOSCLEROSIS WITH ENCEPHALOMALACIA</b> (c) <b>UNKNOWN</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b> <b>UNKNOWN</b> <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Operation 2/18/60 University Hospital, Balto. Md. Trephine</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 17, 1960</b> to <b>April 4, 1960</b> , that I/ (we) last saw the deceased alive on <b>4-4-60</b> 19, and that death occurred at <b>10:35 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Cardad E. Gonzalez</i> M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4/5/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>CARDAD E. GONZALEZ, M.D.</b>				22d. ADDRESS <b>VAH, BALTIMORE 18 MD, FT. HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-8-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight</b>				ADDRESS <b>6009 Harford Rd., Balto. 14, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 11 '60</b>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **48 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

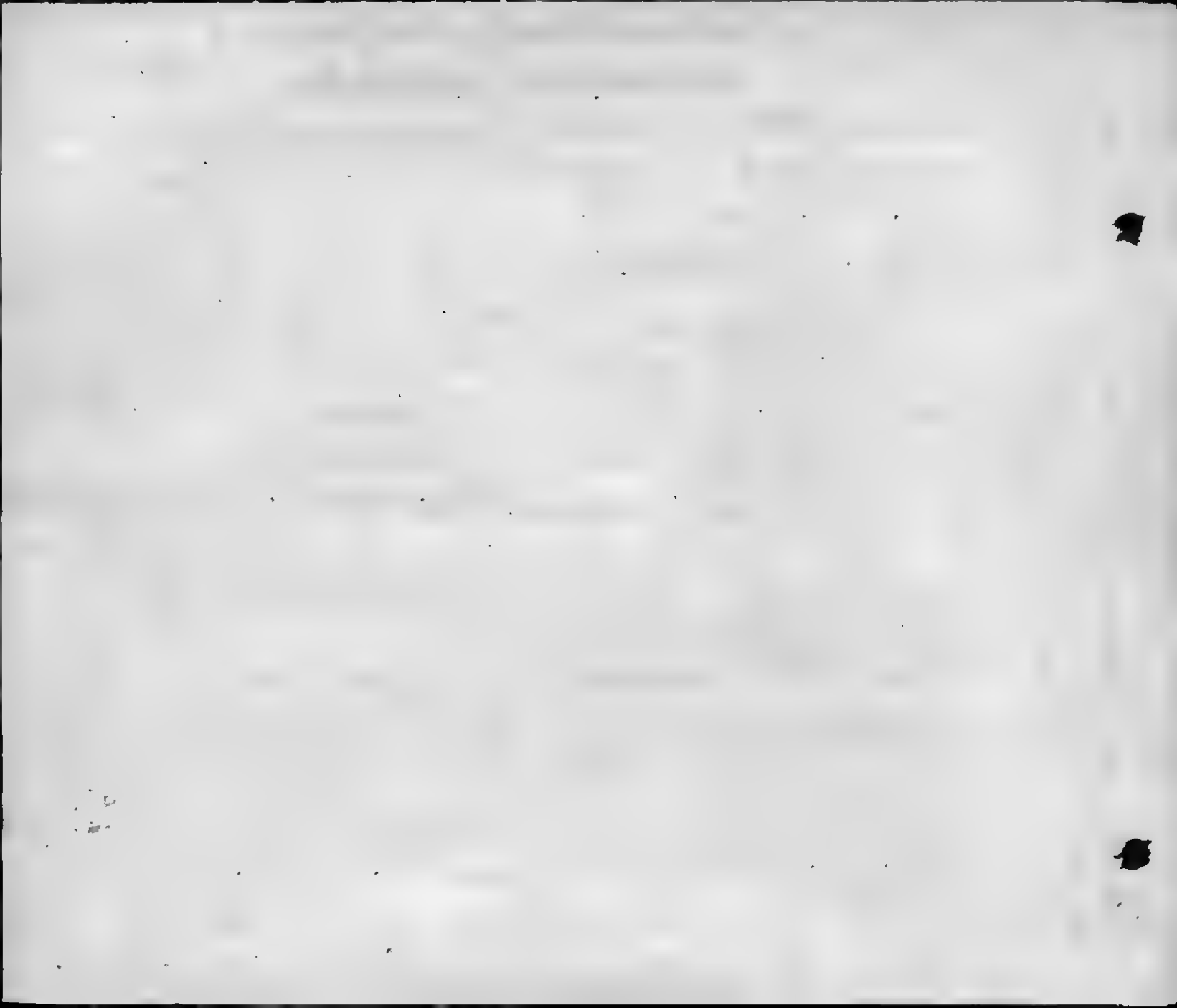
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

4292

Reg. Dist. No. 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore County</u>		STATE <u>Md</u>		COUNTY <u>Balto. City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Mt. Wilson, Maryland</u>		<u>Home</u>		OR TOWN <u>Baltimore 18</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>2643 Maryland Ave</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Vincent</u> (Middle) <u>Leo</u> (Last) <u>Ianneo</u>				(Month) <u>4</u> (Day) <u>17</u> (Year) <u>19 60</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>4/16/1889</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>clothing</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Ianneo</u>				14. MOTHER'S MAIDEN NAME <u>Rose Liberski</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>231-09-8413</u>		17. INFORMANT & ADDRESS <u>Hosp. Records, Mt. Wilson State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Lymphosarcoma</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 month</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Moderately Advanced Pulmonary Tuberculosis</u>				4 years			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>002X</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/30</u> , 19 <u>59</u> , to <u>4/17</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/17</u> , 19 <u>60</u> , and that death occurred at <u>1:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William Newcomer</u>				ADDRESS (Street, city, town, state) <u>M.D. Superintendent, Mt. Wilson, Maryland</u>			
DATE <u>APR 20 '60</u>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 20/60</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		LOCATION (City, town, or county) (State) <u>4430 Belair Rd.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Miller</u>		ADDRESS <u>322 S. High St.</u>	



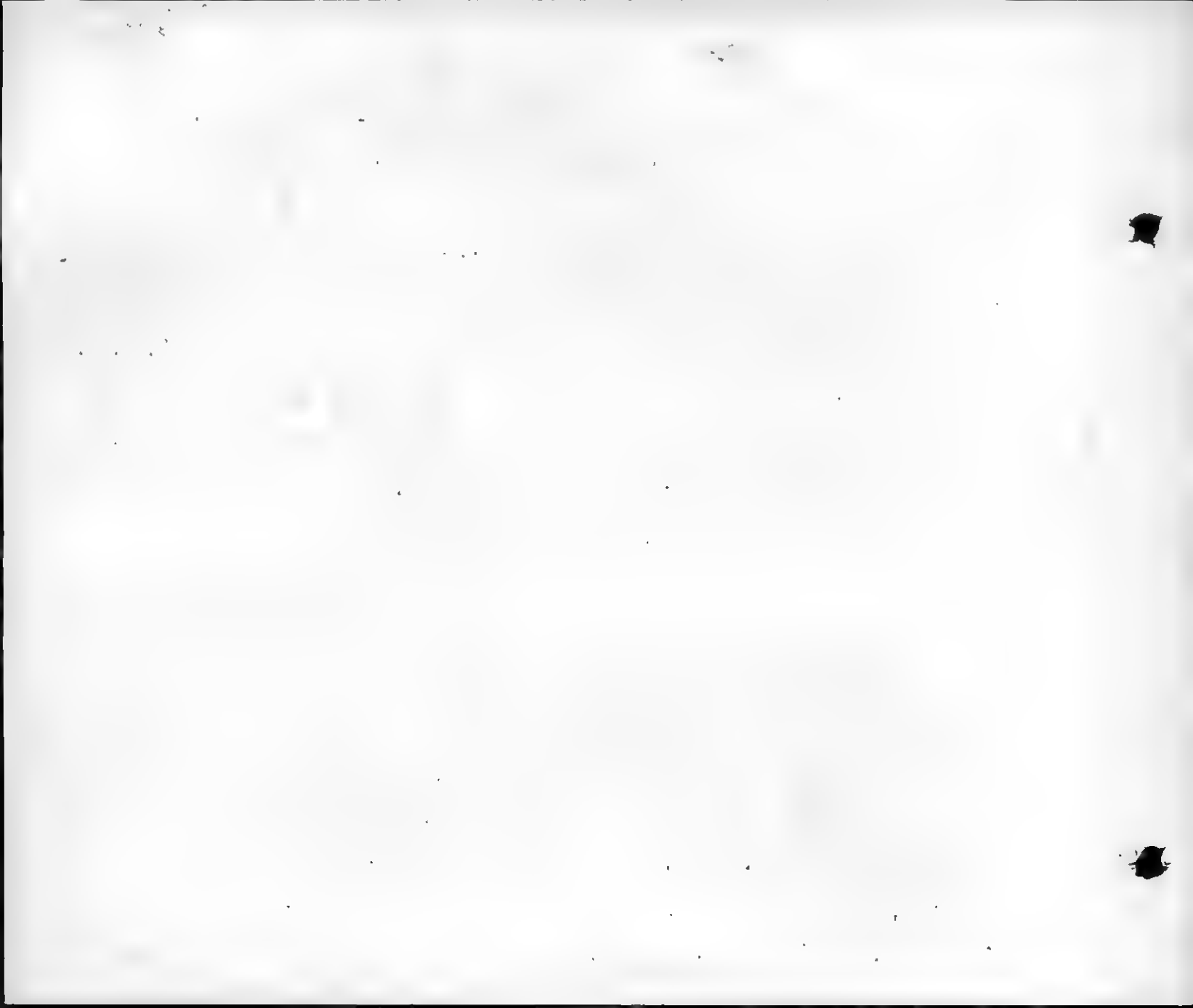
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4293 CERTIFICATE OF DEATH

Reg. Dist. No.

04230

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle Last <b>Jenkins</b>		4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4, 1887</b>
9. AGE (In years last birthday) <b>73</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>trucker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William J. Jenkins</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Wheatley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
INFORMANT <b>Records:</b>		Address <b>SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b>			
DUE TO (b) <b>Generalized arteriosclerosis</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 5, 1960</b> to <b>April 22, 1960</b> , that I last saw the deceased alive on <b>April 22, 1960</b> , and that death occurred at <b>5:45a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Isadore Tuerk</b>		DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 4-22-60</b>	
PHYSICIAN'S NAME (Type) <b>Isadore Tuerk, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/25/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Josephs</b>		22d. LOCATION (City, town, or county) (State) <b>Morgans md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clark Mattingly</b>		ADDRESS <b>Leonardtown, md.</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 27 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64231

4234

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rogers Forge</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>115 Murdock Rd</u>		e. STREET ADDRESS <u>115 Murdock Rd (2)</u>	
3. NAME OF DECEASED (Type or print) <u>Ruth Marie Johnson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-1892</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Wiseman</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Lembach</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Newton P. Johnson</u>		Address <u>115 Murdock Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Hypertension U D (Hypertension)</u> DUE TO (c) <u>Insufficiency.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>2-19-59.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumia of Lung.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-15</u> , 19 <u>55</u> , to <u>4-25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-22</u> , 19 <u>60</u> , and that death occurred at <u>11 A. M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>3711 Falle Ad.</u>			
ACTUAL SIGNATURE <u>Lawrence J. Shuman</u> M.D.		PHYSICIAN'S NAME (Type) <u>Lawrence J. Shuman</u> M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-28-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		22d. LOCATION (City, town, or county) (State) <u>Parkville (Baltimore) MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Glenn F. Beitz</u>		ADDRESS <u>5209 York Rd</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSP.

may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR:

After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Thereafter, it should be filed with the funeral director.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**4295 CERTIFICATE OF DEATH**

04252

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. LENGTH OF STAY IN 1b <b>109 Days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>425 Druid Hill Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>---</b> Last <b>JOHNSON</b>				4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 23, 1897</b>		9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Hodge</b>				14. MOTHER'S MAIDEN NAME <b>Madaleine Johnson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>Clinical Records, VAH, Balto. 18, Md. Fort Howard Div.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF URINARY BLADDER WITH METASTASIS</b> <b>181.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BRONCHO PNEUMONIA</b>							INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 18, 1959</b> to <b>April 5, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 5, 1960</b> , and that death occurred at <b>10:25 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Moses Lichtig</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Moses Lichtig, M.D.</b>				22d. ADDRESS <b>VAH, Balto. Md. Fort Howard Division 4/6/60</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/14/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips, Baltimore 17, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 12 '60</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

MEDICAL CERTIFICATION

the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

181

1

INSTRUCTIONS

**1. ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

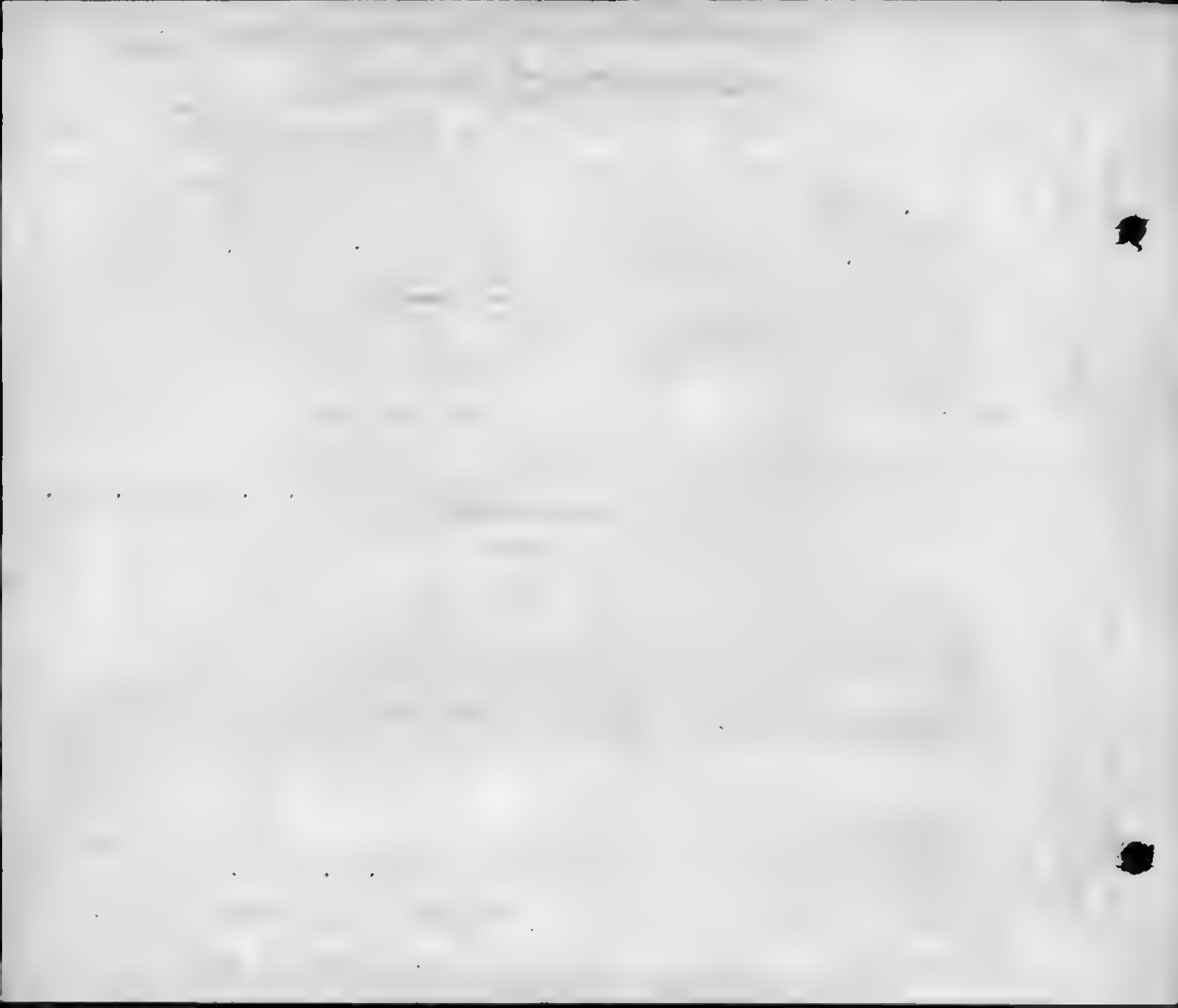
64283

## 4296 CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Baltimore County</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>City</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Mt. Wilson, Maryland</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore 17,</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Mt. Wilson State Hospital</b>				STREET ADDRESS <b>714 N. Payson St.</b> (If rural give location)			
3. NAME OF DECEASED (Type or Print) <b>Elizabeth M. Jones</b>				4. DATE OF DEATH (Month) <b>April</b> (Day) <b>2</b> (Year) <b>1960</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>Colored</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>		8. DATE OF BIRTH <b>2/12/1917</b>	
9. AGE last birthday <b>43</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Richmond Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Brown</b>				14. MOTHER'S MAIDEN NAME <b>Pearl Wyatt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) <b>No</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-10-6073</b>		17. INFORMANT & ADDRESS <b>Hospital Records, Mt. Wilson St. Hosp.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						1 year	
IMMEDIATE CAUSE (A) <b>Pulmonary Tuberculosis</b>							
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Left pneumonectomy</b>							
19a. DATE OF OPERATION <b>3/16/60</b>		19b. MAJOR FINDINGS OF OPERATION <b>Tuberculosis</b>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>1/14/60</b> , 19....., to <b>4/1/60</b> , 19....., that I last saw the deceased alive on <b>4/1/60</b> , 19....., and that death occurred at <b>11:05 AM</b> , from the causes and on the date stated above.							
SIGNATURE <b>William Newcomer</b>				ADDRESS (Street, city, town, state) <b>M.D. Superintendent, Mt. Wilson, Maryland</b>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>4/5/60</b>		NAME OF CEMETERY OR CREMATORY <b>Mt Calvary Cemetery</b>		LOCATION (City, town, or county) (State) <b>Ann Arundel County Md.</b>	
24. REC'D BY REGISTRAR <b>APR 4 '60</b>		REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>A. Halstead</b>		ADDRESS <b>918 Druid Hill Ave.</b>	

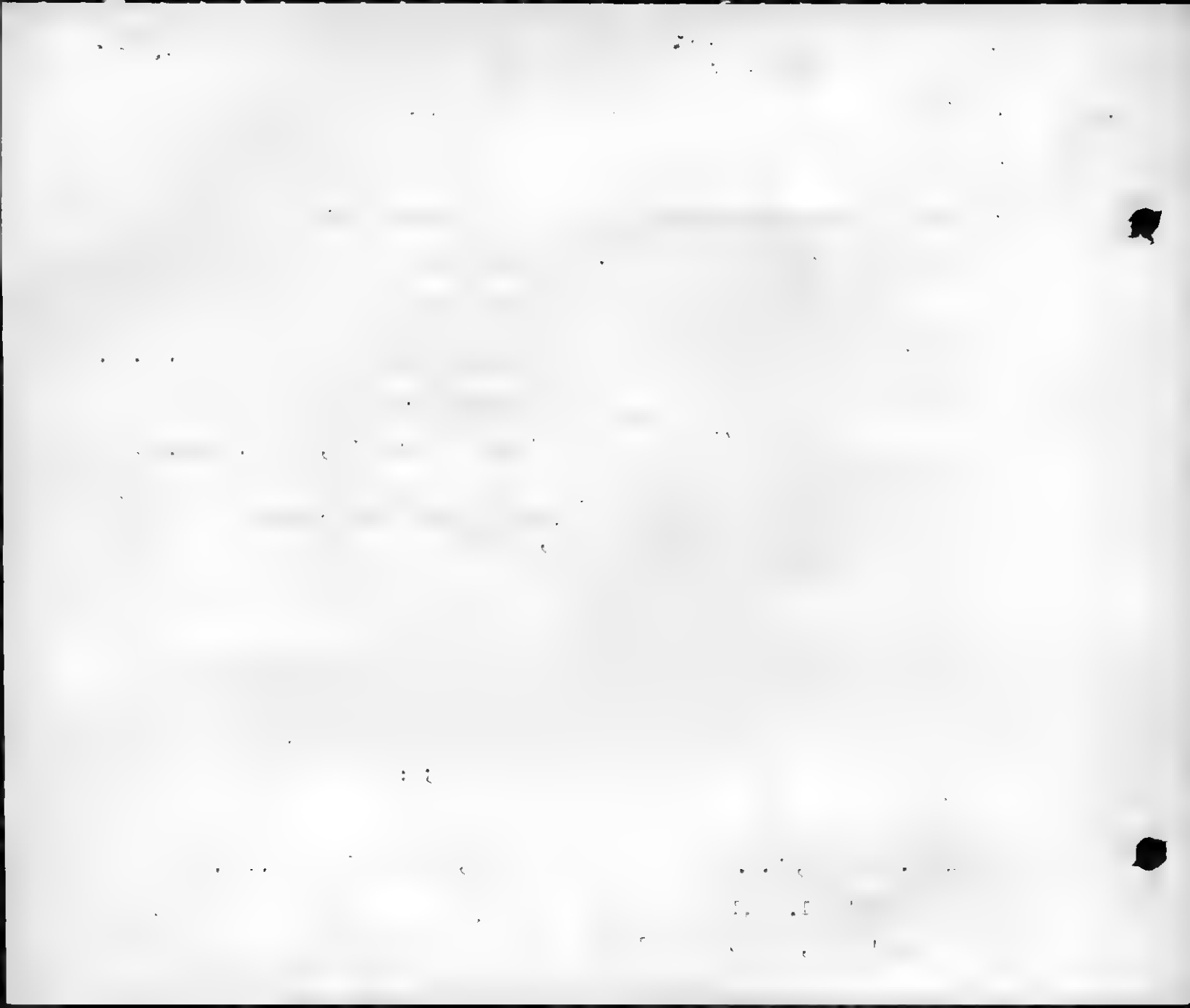


**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**4297** **CERTIFICATE OF DEATH**

04284

1. PLACE OF DEATH <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Mercer</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>29 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hightstown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>171 Stockton Street</b>			
3. NAME OF <b>JAMES</b> First <b>W.</b> Middle <b>JONES</b> Last				4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 24, 1879</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Lewis Jones</b>				14. MOTHER'S MAIDEN NAME <b>Laura Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>10/12/00 6/11/64</b>		17. INFORMANT <b>Clinical Records, VAH, Balto. 18, Md. Ft. Howard/</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> DUE TO <b>HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>ARTERIOSCLEROSIS, MARKED</b> <b>PULMONARY EMPHYSEMA</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>(1)</b> (this hospital) attended the deceased from <b>March 28</b> , 19 <b>60</b> , to <b>April 26</b> , 19 <b>60</b> , that <b>(1)</b> (we) last saw the deceased alive on <b>April 26</b> , 19 <b>60</b> , and that death occurred <b>12:30 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John D. Talbert</b>				M. D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4/26/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M.D.</b>				22d. ADDRESS <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (S, C, R) <b>Removal/Burial</b>		23b. DATE THEREOF <b>Apl. 29, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hightstown, New Jersey</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>				25a. REC'D BY REGISTRAR <b>APR 28 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>	

TO HOSPITAL: The low requires that the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4225

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

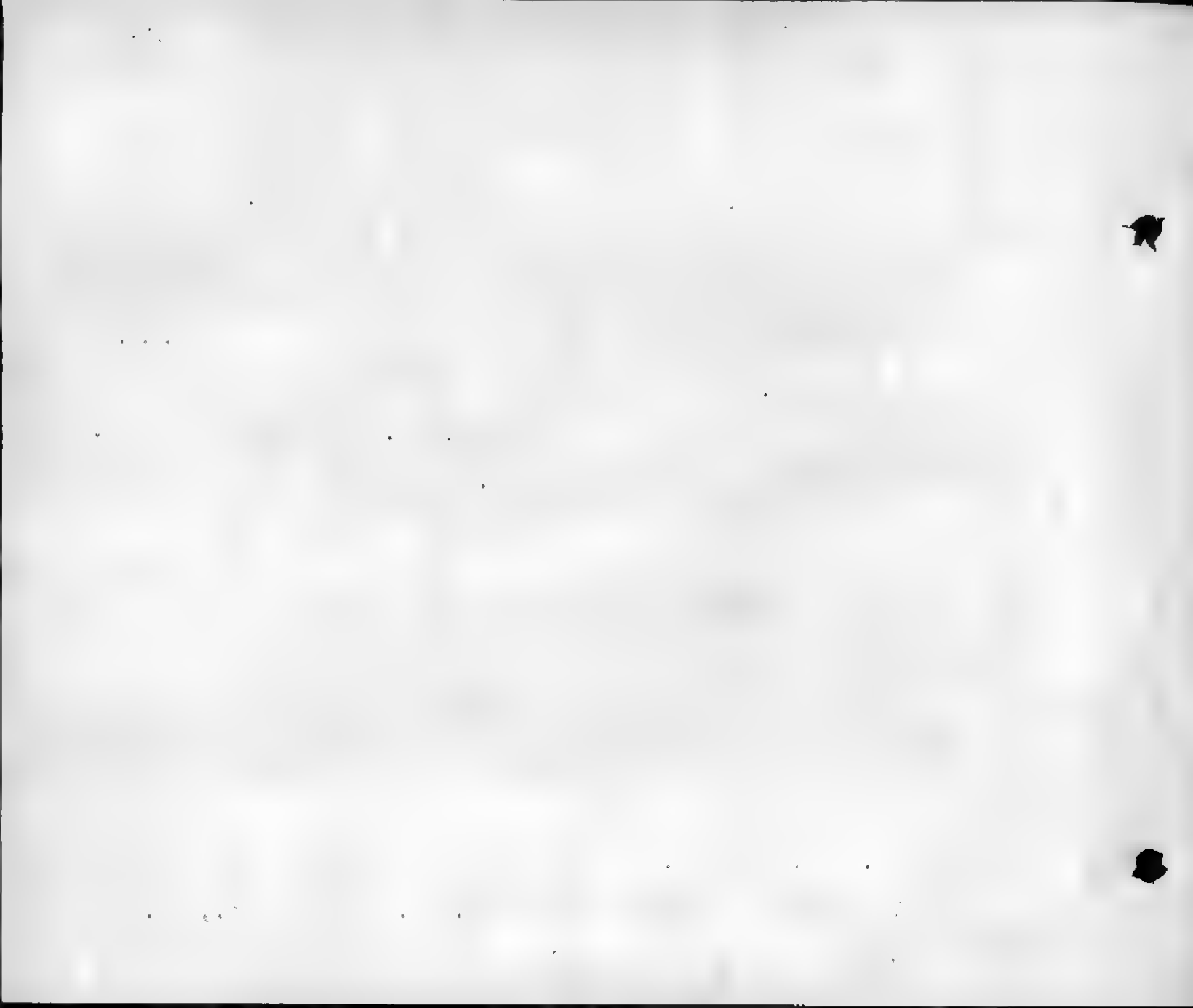
Reg. Dist. No.

64285

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lansdowne</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2913 Hammond Perry Rd.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>57 Lansdowne</b>			
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Joan</b> Last <b>Joy</b>				4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>1960</b>			
5. SEX <b>FEM</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1906</b>	9. AGE (In years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR Months <b>11</b> Days <b>17</b>	IF UNDER 24 HRS. Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Altamont Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter W. Watts</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Horsey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Lillian L. Joy, 2913 Hammonds Perry Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary thrombosis. Cardio vascular disease</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>p. m.</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> "							
ACTUAL SIGNATURE <b>Geo. M. Kieffer</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Geo. M. Kieffer M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Type)		22b. DATE THEREOF <b>5/3/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodrow Ridge Mem. Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Howard Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>				ADDRESS <b>4107 Wilkens Ave</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 4 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

MEDICAL CERTIFICATION

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





4298

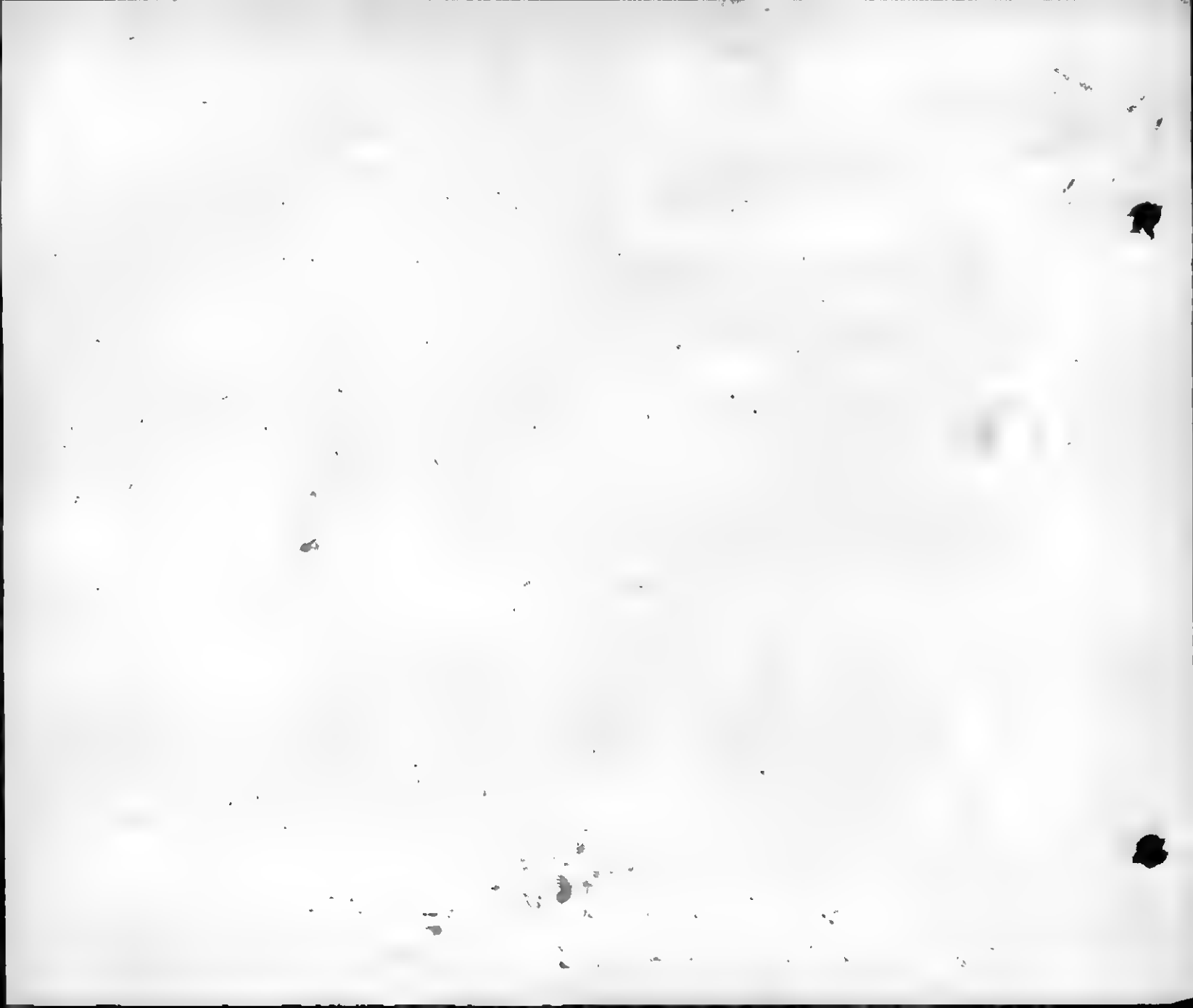
## CERTIFICATE OF DEATH

64206  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8000 PHILADELPHIA RD.</u>				e. STREET ADDRESS <u>8000 PHILADELPHIA RD.</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>—</u> Last <u>KAHLER</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 6, 1886</u>		9. AGE (In years last birthday) <u>73</u> yrs.	10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	11. IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK HAGERT</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH KIRSCHBAUM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>—</u>		INFORMANT Address <u>Mr. George J. Kaller, 8000 Philadelphia</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Spinal</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>4-5 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>26 Feb</u> , 19 <u>60</u> , to <u>24 Apr</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>24 Apr</u> , 19 <u>60</u> , and that death occurred at <u>6 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, City or town, State) <u>2604 Hager Rd, Baltimore Md</u>			
PHYSICIAN'S NAME (Type) <u>[Signature]</u>				DATE SIGNED <u>26/4/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/28/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEM. MORELAND MEMORIAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>2334 Jefferson St</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>APR 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HUSBAND OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
4299

MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

64257

1. NAME OF DECEASED (Type or Print) <b>BLANCHE ELIZABETH KAIN</b>		2. DATE OF DEATH <b>April 18, 1960</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <i>NOT IN HOSPITAL OR INSTITUTION GIVE STREET ADDRESS OF LOCATION</i> <i>Baltimore City</i> <b>Mercy Villa Nursing Home</b>		4. USUAL RESIDENCE (Where deceased lived, If institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN <b>Baltimore</b> (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) <b>3920 Maine Avenue</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>March 30, 1881</b>
9. AGE (In years last birthday) <b>79 years</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. BIRTHPLACE (State or foreign country) <b>Emmitsburg, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry #444444 Lingg</b>		14. MOTHER'S MAIDEN NAME <b>#444444 Virginia Rider</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-20-5003</b>	
17. INFORMANT <b>Frank Joseph Kain, Jr. - 3925 Beech Ave.</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>arteriosclerotic</b> <b>CAUSE OF DEATH</b> (A) <b>Coronary Artery Disease</b> (B) <b>Pneumonia</b> (C) <b>Decubitus ulcer</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b> <b>2 weeks</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>45</b>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Decubitus ulcer</b>			
21. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN		22. DATE OF OPERATION	
23. CONDITION FOR WHICH OPERATION WAS PERFORMED		24. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. I certify that (I) (this hospital) attended the deceased from <b>April 18, 1960</b> to <b>April 18, 1960</b>		26. that (I) (we) last saw the deceased alive on <b>April 18, 1960</b>	
27. and that in my (our) opinion death occurred at <b>3 P.M.</b> , from the causes and on the date stated above.			
28. SIGNATURE <b>Joseph Q. Mather</b>		29. ADDRESS <b>6821 Reisterstown Rd</b>	
30. DATE SIGNED <b>April 20, 1960</b>			
31. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D.			
32. DATE REC'D BY HEALTH DEPT. <b>APR 21 1960</b>		33. NAME OF REGISTRAR <b>Arthur S. Kneel</b>	
34. NAME OF FUNERAL DIRECTOR <b>Ellsworth Armacost</b>		35. ADDRESS <b>4600 Liberty Hgts. Ave</b>	

THIS IS A PERMANENT RECORD.  
IF INFORMATION SHOULD BE CAREFULLY SUPPLIED.  
WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

43-1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

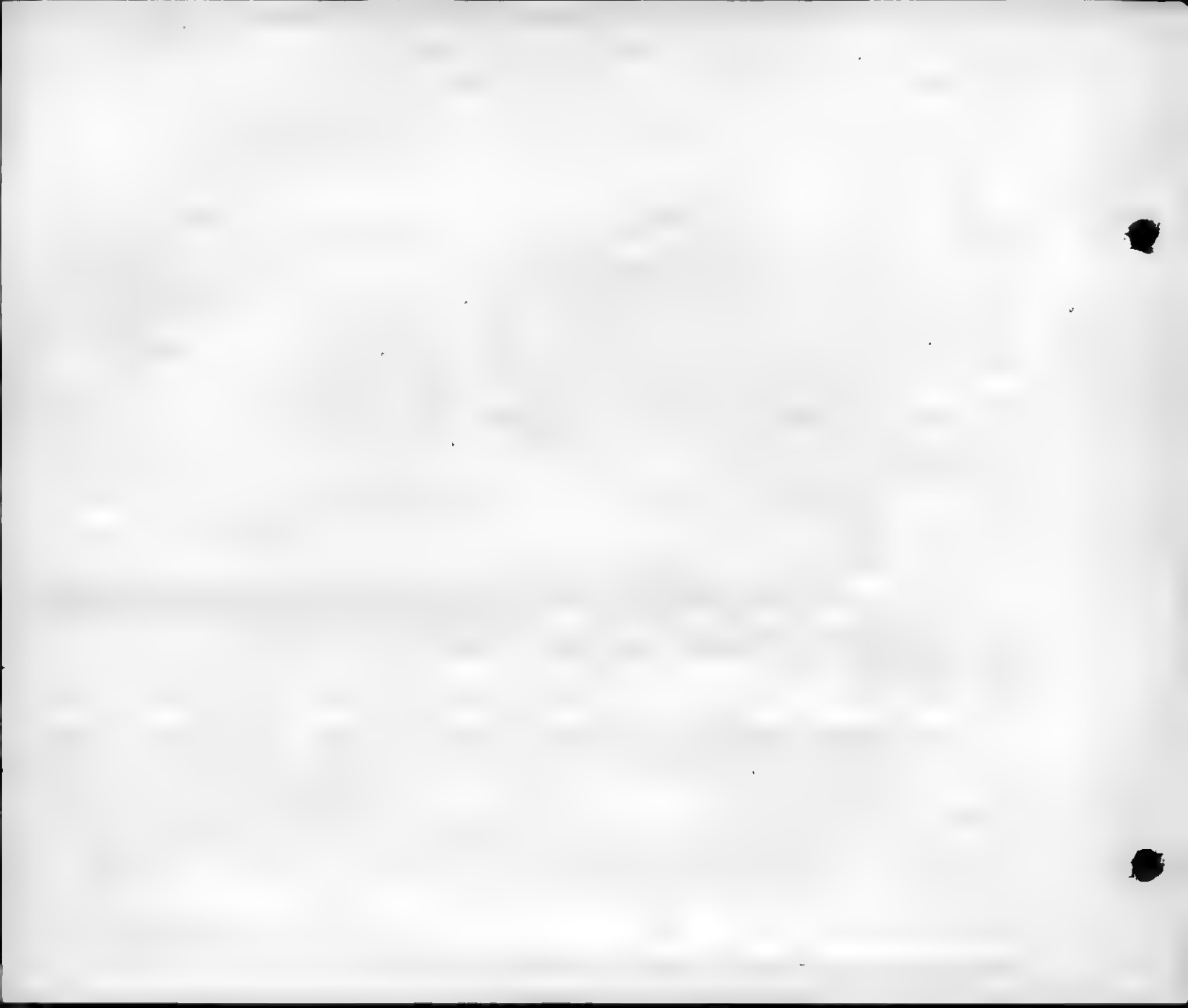
4300

CERTIFICATE OF DEATH

Reg. Dist. No.

04258

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>25 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Caton Ridge Nursing Home</b> <b>Harlem Lane Near Edmondson Ave</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Allen</b> First Middle Last		4. DATE OF DEATH <b>April 23 19 60</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb 29, 1895</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR <b>1</b> Months <b>25</b> Days <b>0</b> Hours <b>0</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11c. BIRTHPLACE (State or foreign country) <b>Hampstead, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Franklin Kelbaugh</b>		14. MOTHER'S MAIDEN NAME <b>Emma <del>RAFF</del> Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Kenneth S. Carmody, 513 Munsey Bldg</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia Pt Colours</b> <b>470X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Age &amp; Debility</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old 7 Onus 2 Parkinson</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 29, 1960</b> to <b>4/23, 1960</b> that I last saw the deceased alive on <b>4/22, 1960</b> , and that death occurred at <b>9 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4605 Edmondson Ave</b> DATE SIGNED <b>4/26/60</b>			
ACTUAL SIGNATURE <b>Cliff Ratliff Jr</b> M.D.		DATE SIGNED <b>4/26/60</b>	
PHYSICIAN'S NAME (Type) <b>CLIFF RATLIFF, Jr</b>		BALTO 29 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-28-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Foreston Church Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Foreston, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>David R. Martin</b> ADDRESS <b>1902 Eutaw Place</b>		24a. REC'D BY REGISTRAR <b>APR 28 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Cliff R. Ratliff</b>	



4301

CERTIFICATE OF DEATH

64239

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ELK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-KOCKDALE</u>				c. LENGTH OF STAY IN 1b <u>8 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3-70 MARSHALL LANE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM COLVILLE KIRK</u>				4. DATE OF DEATH Month Day Year <u>4 19 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/31/82</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM H. KIRK</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE WALLACE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>W. Raymond KIRK</u> Address <u>2645 MARSHALL LANE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DEGENERATIVE HEART DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>8 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/15, 1949</u> to <u>4/10, 1960</u> , that I last saw the deceased alive on <u>7/18, 1960</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8204 LIBERTY RD, BALTIMORE, MD</u> DATE SIGNED <u>4/19/60</u>							
ACTUAL SIGNATURE <u>Edwin L. Pierpont</u> M.D.							
PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4/13/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ant. O. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Randallstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u> ADDRESS <u>8728 Liberty Road</u>				24a. REC'D BY REGISTRAR DATE <u>APR 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Merrill</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

420.8



**4302** **DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**64240**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>10 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>4301 Valley View Avenue (6)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ALBERT R. KUEHL</b>			4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>19 60</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 14, 1898</b>	9. AGE (In years last birthday) <b>61</b> yrs	10. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>19</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician-Refrigeration U.S. Civil Serv. Freeport, Illinois</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. A.</b>				
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>Herman Kuehl</b>			14. MOTHER'S MAIDEN NAME <b>Ernestine Giese</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 212-03-567</b>		17. INFORMANT <b>Clinical Records, VAH, Balto. 18, Md., Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>491 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Thrombosis, multiple with bilateral hemiparesis - Duration Unk.</b> <b>Multiple Decubitus Ulcers - Duration Unknown.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>p. m.</b> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>April 1, 1960</b> , to <b>April 11, 1960</b> , that <b>10</b> (we) last saw the deceased alive on <b>April 11, 1960</b> , and that death occurred at <b>3:30 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Caridad E. Gonzalez</b>		22b. DATE SIGNED <b>4/11/60</b>		22c. PHYSICIAN'S NAME (Type) <b>CARIDAD E. GONZALEZ, M.D.</b>			
22d. ADDRESS <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>							
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/14/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>			
23d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard Ruck</b>		ADDRESS <b>5305 Harford Road, Balto. 14 Md.</b>		25a. REC'D BY REGISTRAR <b>APR 13 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

491X

1-6  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Items 20&21 Film 263  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**4303 MEDICAL EXAMINER'S CERTIFICATE OF DEATH** **64241**

1. PLACE OF DEATH  
a. COUNTY **Baltimore** MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Rossville**  
c. LENGTH OF STAY IN 1b  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tel, give street address) **9223 Philadelphia Road**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE **Maryland** b. COUNTY **Baltimore**  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Rossville**  
d. STREET ADDRESS **9223 Philadelphia Road** e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last  
**HENRY KUEHNE**

4. DATE OF DEATH Month Day Year  
**April 15 1960**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH  
**June 3, 1903** 9. AGE (In years last birthday) **56** yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Carpenter** 10b. KIND OF BUSINESS OR INDUSTRY **Construction** 11. BIRTHPLACE (State or foreign country) **Baltimore, Md.** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Robert Kuehne** 14. MOTHER'S MAIDEN NAME **Mary Hax**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. 17. INFORMANT **Mrs. Ethel Whitlock** Address **9223 Phila. Rd.**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Gunshot wound of abdomen**  
DUE TO (b) **116X**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) **Shot self with double barreled shotgun**

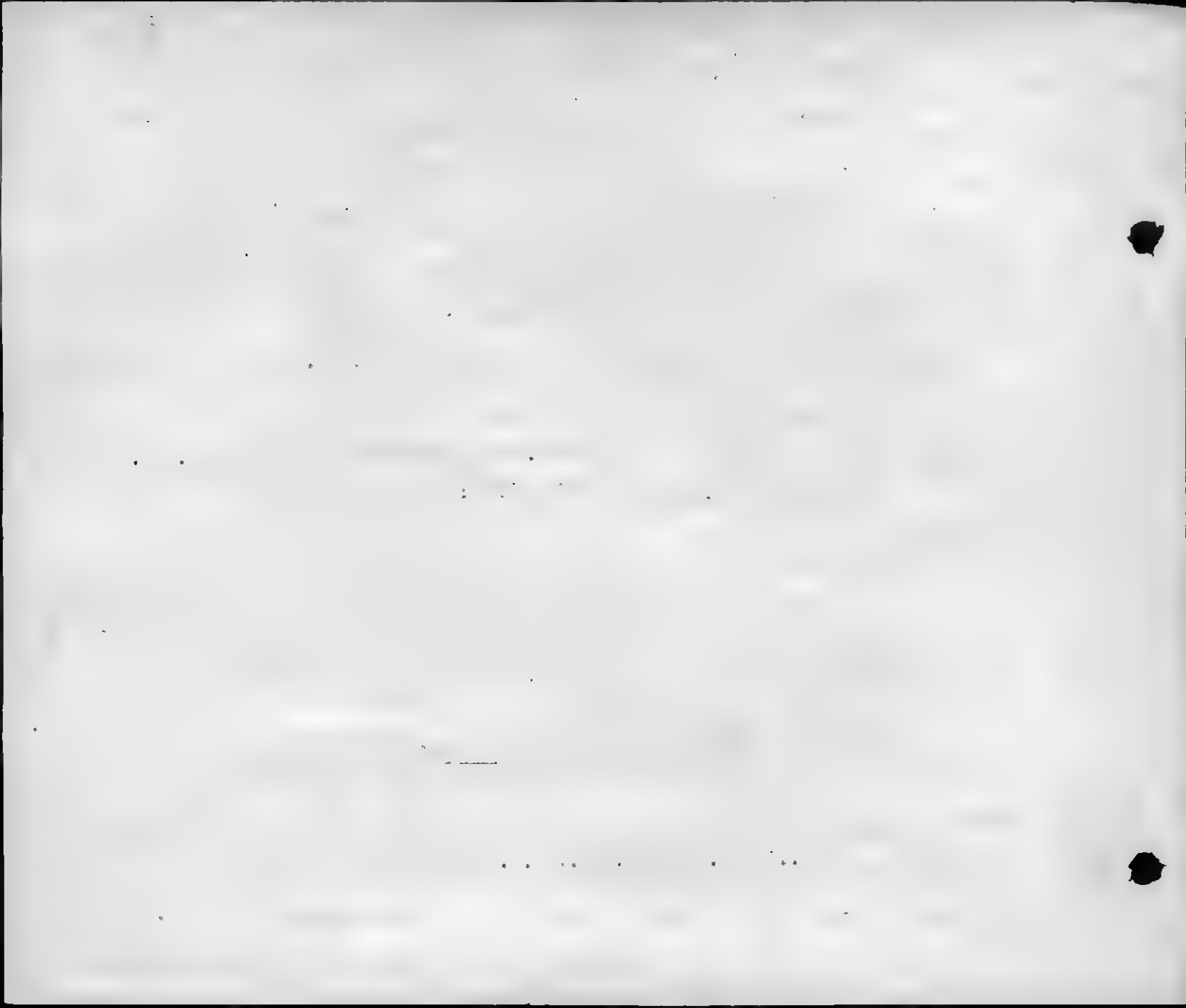
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 **39** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **Home** 20f. (City or town) (County) (State) **Baltimore Md.**

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **William V. Lovitt, Jr., M.D.** M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ DEPUTY MEDICAL EXAMINER ☐ DATE SIGNED **4/16/60**

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **4-19-1960** 22c. NAME OF CEMETERY OR CREMATORY **Zion Lutheran** 22d. LOCATION (City, town, or country) (State) **Stemmers Run, Md.**

23. FUNERAL DIRECTOR **Lassahn Funeral Home** ADDRESS **7401 Belair Rd.** 24a. REC'D BY REGISTRAR **APR 21 '60** 24b. REGISTRAR'S SIGNATURE **Charles E. Hantz**



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

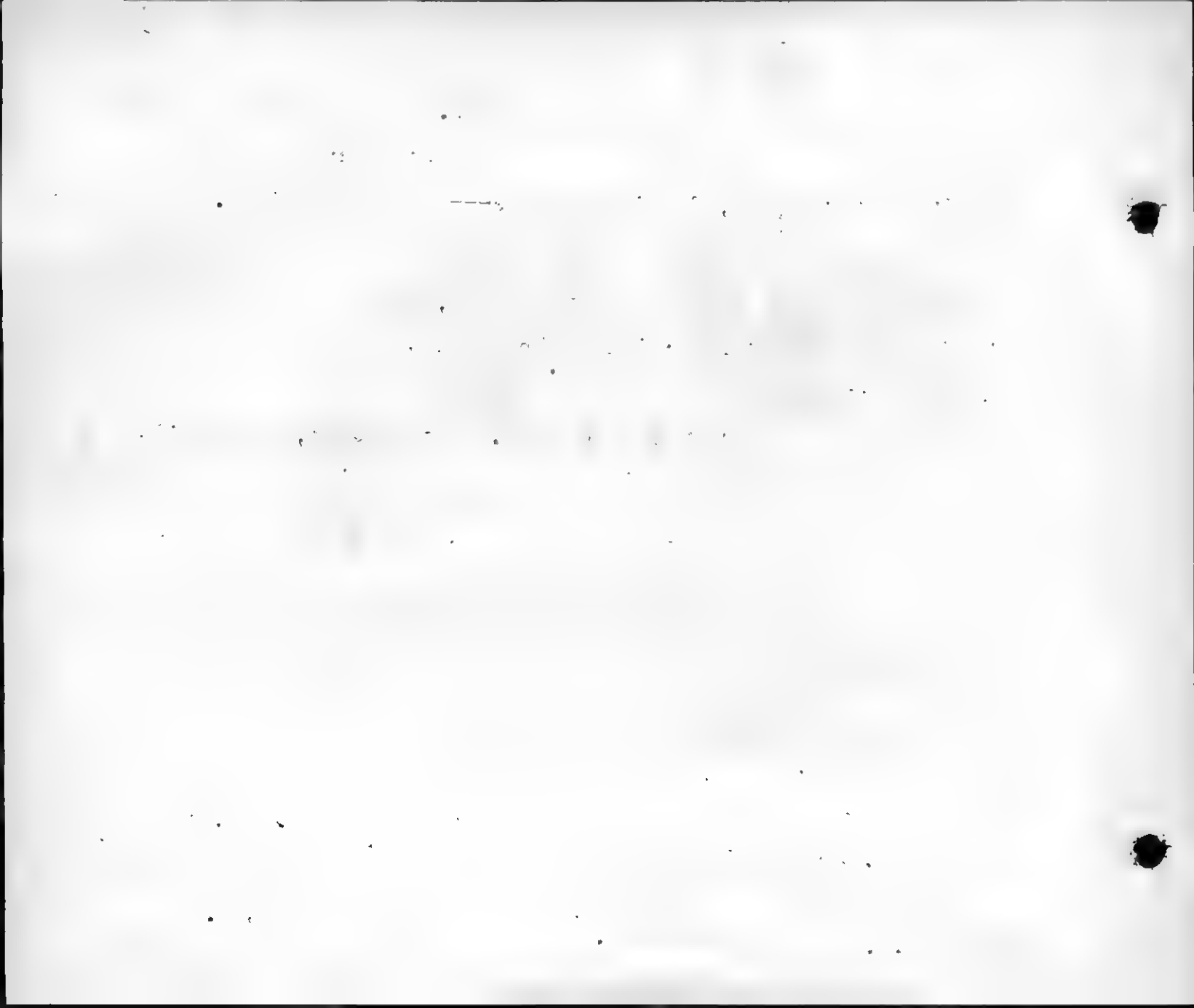
Reg. Dist. No.

<b>4304</b> 1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>56 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(5611 Magnolia Avenue) Baltimore 15</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>5611 Magnolia Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>CLARENCE E. LANDES</b>				4. DATE OF DEATH <b>April 6 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>May 17, 1891</b>		9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Metal Products Co.</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Wellington Landes</b>			
14. MOTHER'S MAIDEN NAME <b>Mahalia Hedrick</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			
16. SOCIAL SECURITY NO. <b>214-02-1143A</b>		17. INFORMANT <b>Clinical Recrds, VAH, Balto. 18, Md. Fort Howard Div.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Arterio-sclerotic HD</b> Conditions, if any, which gave rise to immediate cause (b) <b>Arterio-sclerosis Generalized</b> (c), stating the underlying cause last, DUE TO <b>Arterio-sclerosis Generalized</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John C. Collins</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4-6-60</b>			
EXAMINER'S NAME (Type) <b>John C. Collins</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/8/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>			
22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE APR 7 '60</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Lowman</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any details necessary, please execute it in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.









TO BE COMPLETED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Iter. 1. M.D. 3261 4-5/60 cap

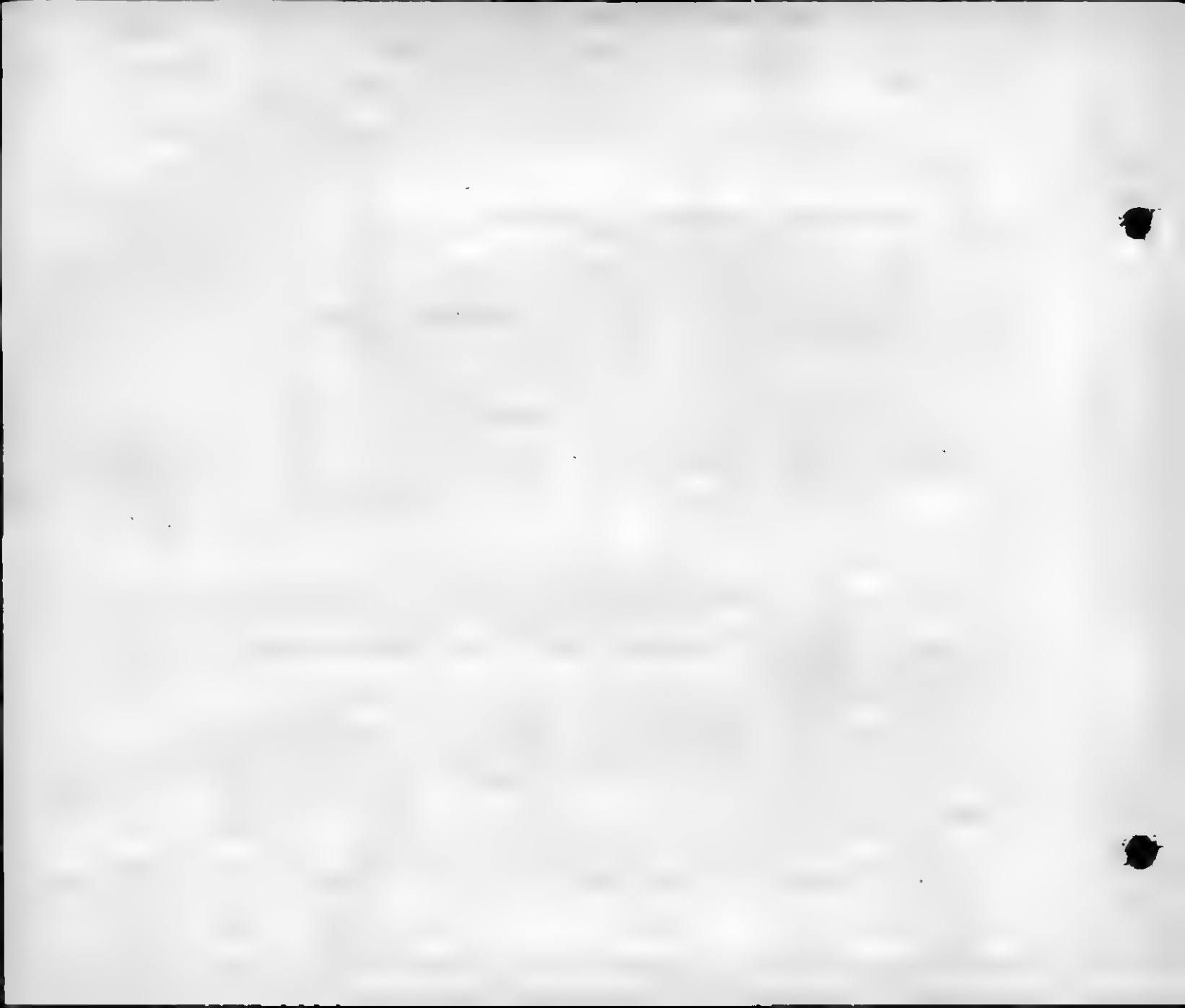
04244

4306

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Rockdale</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Villa Nova- Balto. Co.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Barbara</u> Middle <u>Marie</u> Last <u>Lawler</u>				d. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 19/1892</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Allegation Lady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hecht May Co</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u>Francis Swarz</u>				14. MOTHER'S MAIDEN NAME <u>Mary Kahlech</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-34-5249</u>		17. INFORMANT <u>Norman Lawler Jr</u>		Address <u>4015 Bedford Rd Balto Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(1) - Malignancy of Ascending Colon with Liver Metastases</u> DUE TO <u>Cholecystitis &amp; Cholelithiasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary Anemia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u> <u>2 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Aug 24</u> 19 <u>59</u> , to <u>April 20</u> 19 <u>60</u> , that I last saw the deceased alive on <u>April 19</u> 19 <u>60</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl L. Chambers</u>				M.D. <u>4108 Liberty Hts Balto-7-Md</u> DATE SIGNED <u>4-20-60</u>			
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>				<u>4108 Liberty Hts Balto-7-Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Apr 27/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Mt Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry Harmoncost</u>				ADDRESS <u>4204 Ridgewood Ln</u>		24a. REC'D BY REGISTRAR DATE <u>APR 21 60</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. S. Plana</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

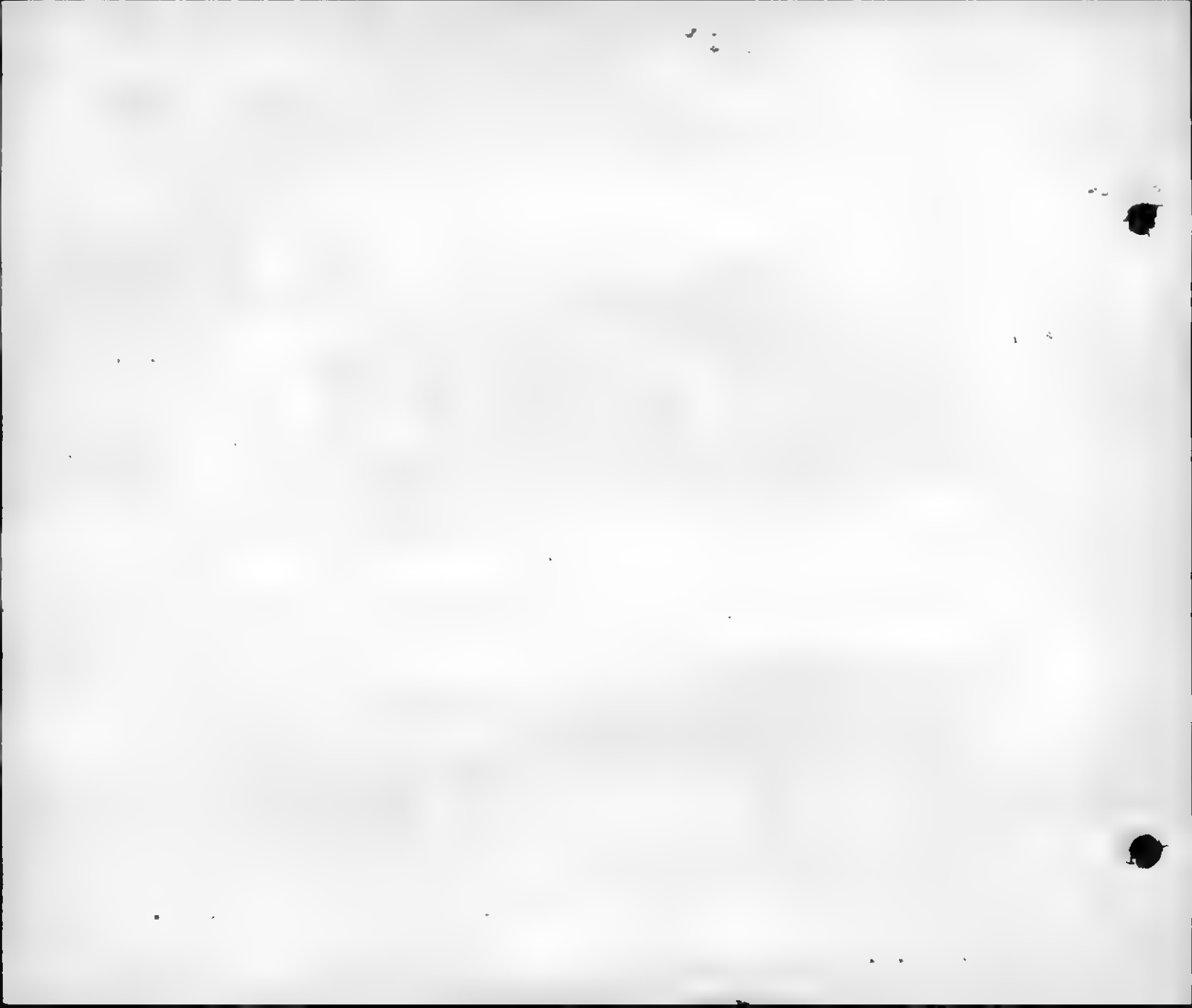
4307

## CERTIFICATE OF DEATH

64245  
Reg. Dist. No.

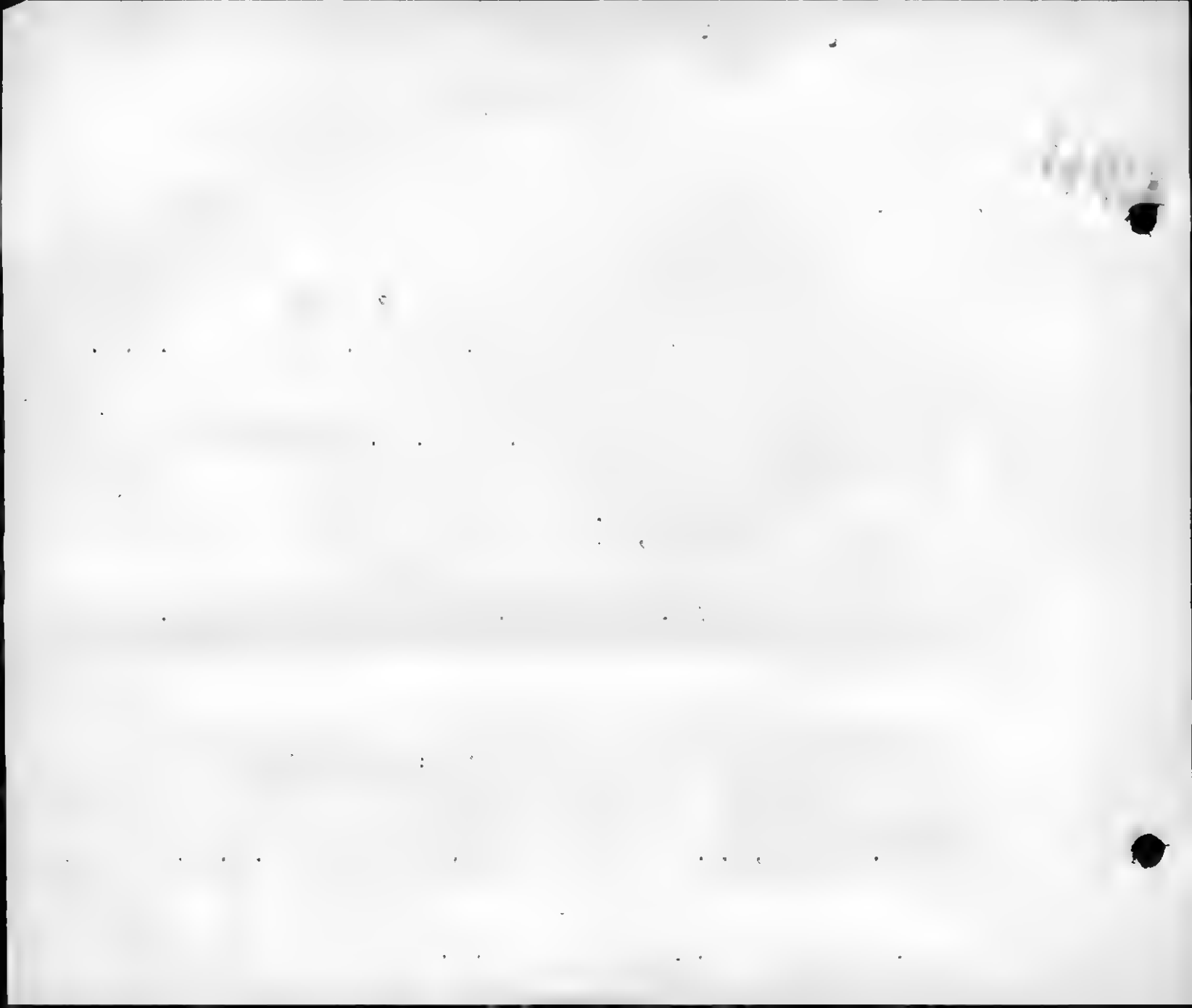
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2yr 1mth 2dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Leffet</b> Last		4. DATE OF DEATH Month <b>4</b> Day <b>25</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 6, 1872</b>
9. AGE (In years last birthday) <b>88</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jacob Leffet</b>		14. MOTHER'S MAIDEN NAME <b>Catherine ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service] <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 10, 1960</b> to <b>April 25, 1960</b> , that I last saw the deceased alive on <b>April 25, 1960</b> , and that death occurred at <b>7:45 p.m.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Bruce R. [illegible]</b> M.D.		SPRING GROVE STATE HOSPITAL <b>4/25/60</b>	
PHYSICIAN'S NAME (Type) <b>BRUCE R. [illegible]</b>		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/28/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Nichols Memorial Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Odenton, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D.4101 Edmondson A</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <b>APR 28 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. [illegible]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



64246

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>43 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1116 Luzerne Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>HENRY</b>		Middle <b>----</b>		Last <b>LEWIS</b>	
4. DATE OF DEATH		Month <b>April</b>		Day <b>12</b>		Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 29, 1898</b>		9. AGE (In years last birthday) <b>61</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Finisher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cement</b>		11. BIRTHPLACE (State a foreign country) <b>Gifford Co, N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Ida Lewis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>217-01-1038</b>		17. INFORMANT <b>Baltimore 18, Maryland Clin. Rec. Vet. Adm. Hospital, Ft. Howard Division</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> DUE TO <b>CONGESTIVE HEART FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>PNEUMONIA, BILATERAL</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE</b> <b>ACUTE</b> <b>ACUTE</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Post Operative Evisceration. Operations. 1. Exploratory Lapatomy-3/30/60. 2. Secondary Closure of Evisceration. (Eventration &amp; Cascade Stomach)</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>February 29, 1960</b> to <b>April 12, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 12, 1960</b> , and that death occurred at <b>P. M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Cardinal E. Gonzalez</i> M.D.				22b. DATE SIGNED <b>4/13/60</b>		22c. PHYSICIAN'S <b>CARDINAL E. GONZALEZ, M.D.</b>	
22d. ADDRESS <b>VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION</b>							
23a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-16-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Calvary</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Randolph J. Collick</b>				25a. REC'D BY REGISTRAR <b>APR 18 '60</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

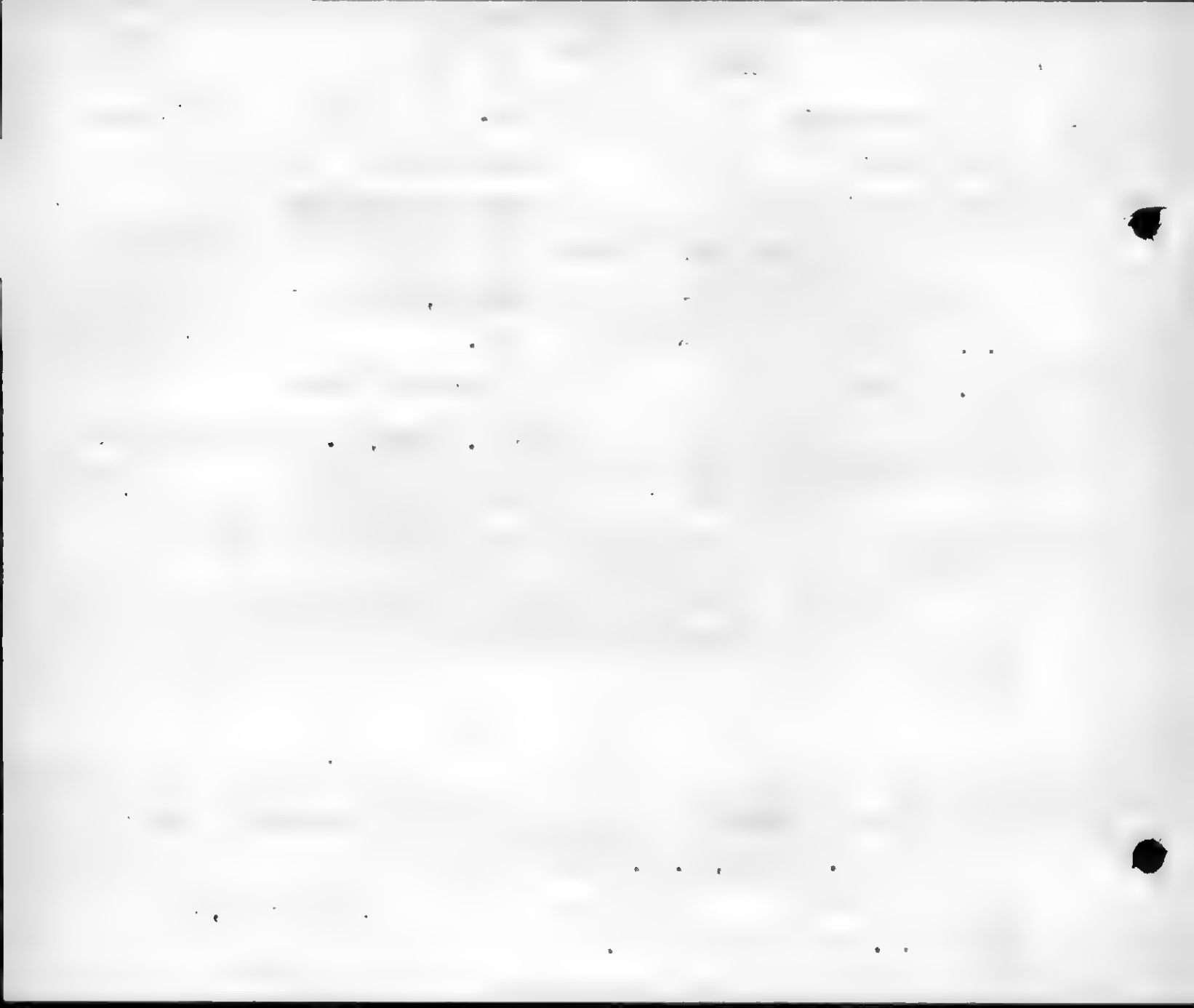


4309 CERTIFICATE OF DEATH

64247  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) STATE <b>MD.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>945 Southridge Rd</b>		d. STREET ADDRESS <b>945 Southridge Rd</b>	
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>May</b> Last <b>Lloyd</b>		4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 7, 1889</b>
9. AGE (In years last birthday) <b>71</b> yrs		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>	11. IF UNDER 24 HRS Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wm. Crofoot</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Merson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>1</b>		16. SOCIAL SECURITY NO. <b>Andrew J. Lloyd, Jr.</b>	
17. INFORMANT <b>Andrew J. Lloyd, Jr.</b>		Address <b>943 Southridge Rd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Hypertensive CVD</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/11</b> , 19 <b>59</b> , to <b>4/23</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>3/31</b> , 19 <b>60</b> , and that death occurred at <b>9 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Max J. Miller</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>1047 Ingleside Ave</b>	
PHYSICIAN'S NAME (Type) <b>Max J. Miller, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/27/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore 29, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D. 4101</b>		ADDRESS <b>Edmondson Ave.</b>	
24a. REC'D BY REGISTRAR <b>APR 26 60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Miller</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

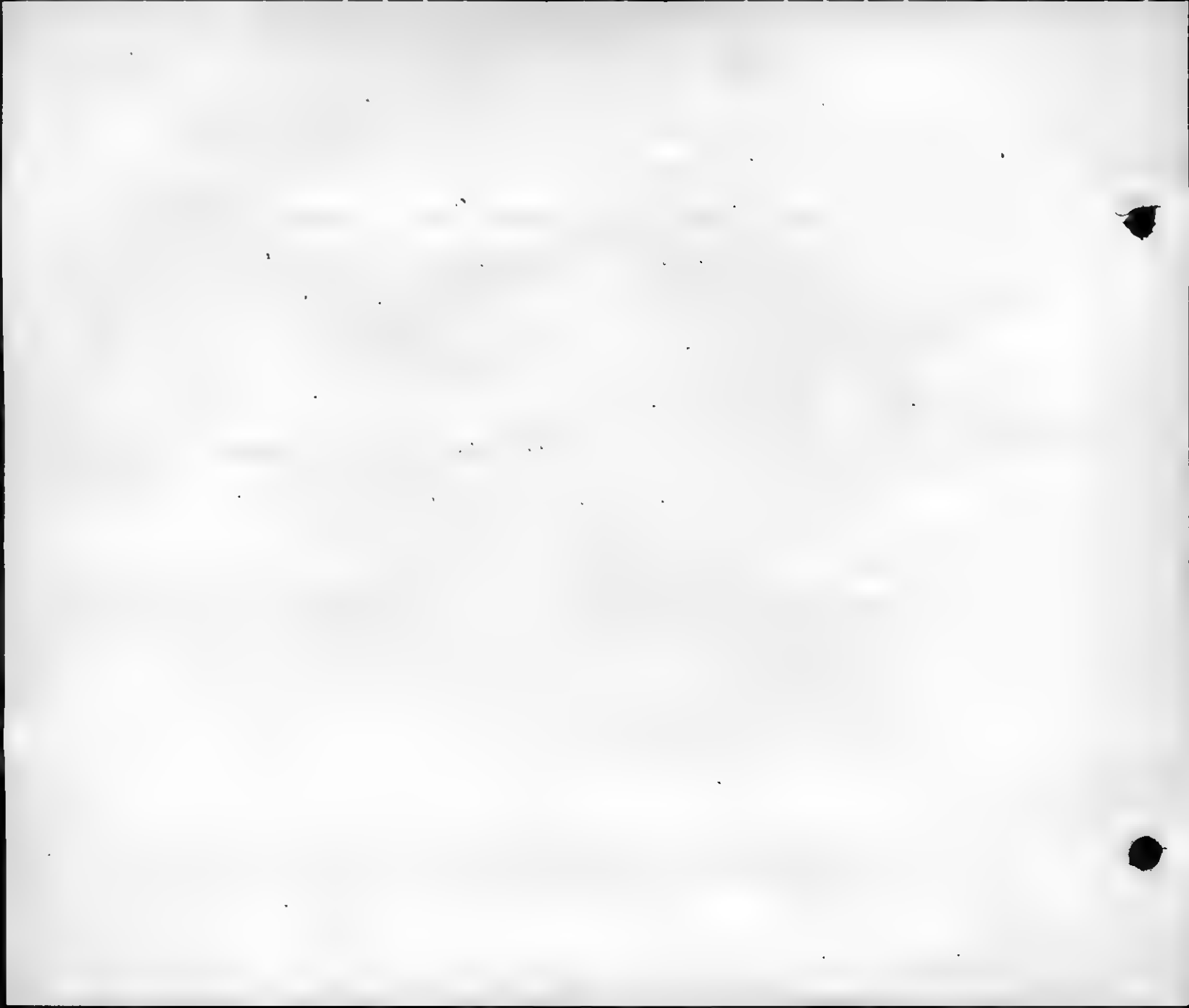
4310

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01218

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>340</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Forest Haven</i>				d. STREET ADDRESS <i>613 N. Bentall St.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Marion Daisy Manges</i> First Middle Last				4. DATE OF DEATH <i>April 3 1960</i> Month Day Year			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1873?</i>		9. AGE (In years last birthday) <i>86</i> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>James W. Brannan</i>				14. MOTHER'S MAIDEN NAME <i>Hall</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT <i>Nettie McShane</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>ARTERIO SCLEROTIC CARDIO- VASCULAR DISEASE</i> DUE TO (b) <i>CORONARY THROMBOSIS</i> DUE TO (c) <i>SEMI-VEGETARY</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>2/28 1960</i> to <i>4/3 1960</i> , that (I) (we) last saw the deceased alive on <i>4/3 1960</i> , and that death occurred at <i>1 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>John H. Shaw</i>				22b. DATE SIGNED <i>4/4/60</i>			
22c. PHYSICIAN'S NAME (Type) <i>John H. Shaw M.D.</i>				22d. ADDRESS <i>1800 E. Edmonson Ave. KEN W. 1840</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>4/6/60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>London Park</i>		23d. LOCATION (City, town or county) (State) <i>Balto. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>McCratt &amp; Son</i> ADDRESS <i>-28-</i>				25a. REC'D BY REGISTRAR DATE <i>APR 6 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4311

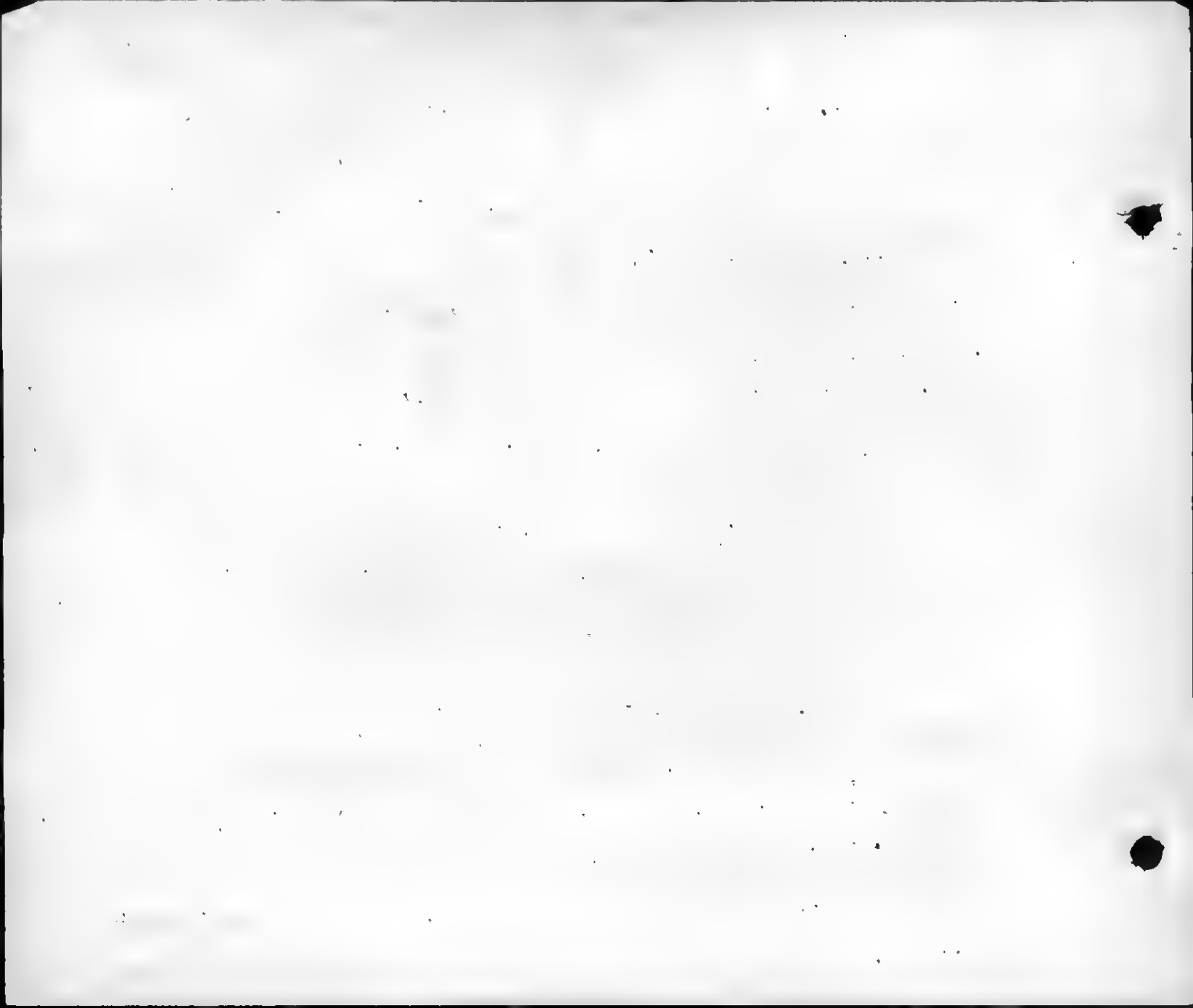
Item 12 Film G261 4-19-60 et

## CERTIFICATE OF DEATH

Reg. No. 4249

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8702 Ashford Road</i>		e. STREET ADDRESS <i>8702 Ashford Road</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mr. Nicholas C. Maros</i>		4. DATE OF DEATH Month Day Year <i>April 6th 1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 2, 1882</i>
9. AGE (In years last birthday) <i>77</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Restaurant Operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Greece</i>	
11. BIRTHPLACE (State or foreign country) <i>Greece</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Constantine Maros</i>		14. MOTHER'S MAIDEN NAME <i>Eugenia</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>1</i>	
17. INFORMANT Address <i>Mrs. Emma P. Maros, 8702 Ashford Road.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial degeneration</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Coronary Artery disease</i> DUE TO (c) <i>Generalized atherosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Marked debilitation.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 1953</i> to <i>Apr 1960</i> that I last saw the deceased alive on <i>Apr 6 1960</i> and that death occurred at <i>3:00 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank T. Kasir</i> M.D.		ADDRESS (Street, city or town, state) <i>9005 Harford Rd Baltimore, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>FRANK T. KASIR JR</i>		DATE SIGNED <i>4/7/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/4/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Greek Orthodox Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR DATE <i>APR 8 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krasch</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64250



4312

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>2919 E. Joppa Road</i>				d. STREET ADDRESS <i>2919 E. Joppa Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mr. Claude</i> Middle <i>Mc Cormick</i> Last <i>Mc Cormick</i>				4. DATE OF DEATH Month <i>April</i> Day <i>27th</i> Year <i>19 60</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 22, 1897</i>	9. AGE (In years last birthday) <i>63</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Paper Route Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Kamas, Utah</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Calvin Mc Cormick</i>				14. MOTHER'S MAIDEN NAME <i>Martha Walker</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <i>Mrs. Bertha C. Mc Cormick</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Insuff &amp; Hypertension</i> DUE TO (c) <i>Arteriosclerotic Cardiovascular Disease</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <i>19</i> e. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John C. Hyle</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>JOHN C. Hyle</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/2/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR <i>May 2 '60</i>	
				24b. REGISTRAR'S SIGNATURE <i>Calvin S. Hanna</i>			





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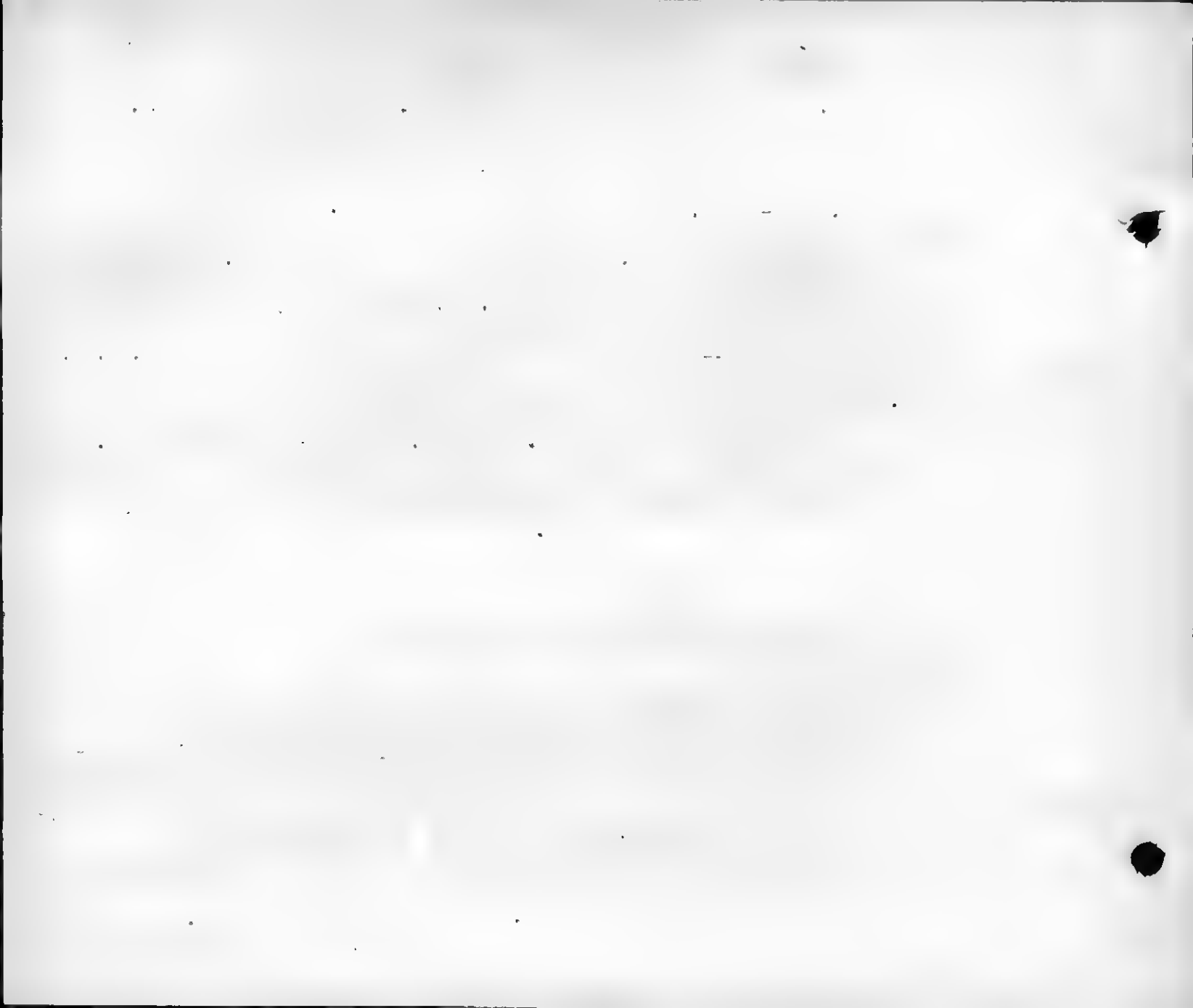
**HOSPITAL** may be  
**FUNERAL** page 3  
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VR A1S {4}  
ISM ■/S9

## 43.3

64251

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>Rodgers Forge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Conval. Home-301 W. Chesapeake Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>META L. McINTYRE</b>		4. DATE OF DEATH Month <b>Apr.</b> Day <b>15</b> Year <b>1960</b>	
5 SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jul. 19, 1890</b>
9 AGE (In years last birthday) <b>69</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Samuel J. Ervin</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Campbell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>Mr. Philip E. McIntyre-118 Dumbarton Rd. #12</b>	
17. INFORMANT <b>Mr. Philip E. McIntyre-118 Dumbarton Rd. #12</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>581.0</b> IMMEDIATE CAUSE (a) <b>Cirrhosis of the Liver</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>4 yrs.</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a. m.</b> Month <b>19</b> Day <b>19</b> Year <b>1960</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 10, 1958</b> to <b>April 15, 1960</b> that (I) (we) last saw the deceased alive on <b>April 5, 1960</b> and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Laurence C. Post</b>		22b. DATE SIGNED <b>4-18-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>LAURENCE C. Post</b>		22d. ADDRESS <b>6805 York Rd. Baltimore Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/18/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickner &amp; Sons - Balto</b>		25a. REC'D BY REGISTRAR <b>DATE APR 18 60</b>	
25b. REGISTRAR'S SIGNATURE <b>Wm. J. Dickner</b>			





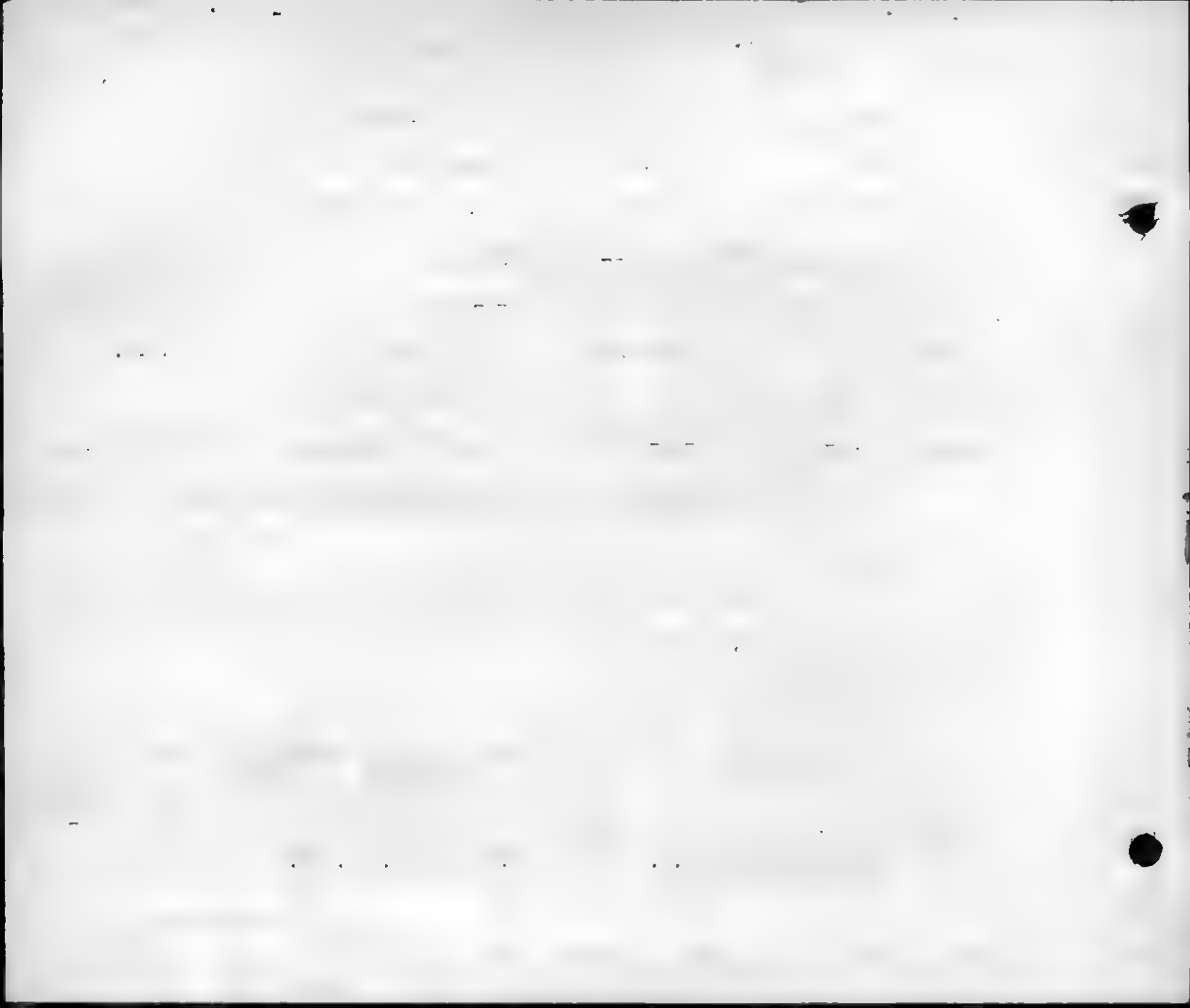
**ATTENTION: DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, the funeral director, may be released by the hospital or attending physician. Pages 1 and 2 should be filled with the funeral director, and in any event within 72 hours after death. Then please remove carbon papers. Pages 3 and 4 should be filled with the State Board of Health prior to burial, cremation, or removal.

VR A1S (4)  
ISM 9/59

## 04252

4314

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>38 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		3014	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>721 HARLEM AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM -- McMATH</b>				4. DATE OF DEATH Month Day Year <b>APRIL 8 1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>COLORED</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-7-1894</b>	
9. AGE (In years last birthday) <b>65</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GROOM</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RACE TRACK</b>		11. BIRTHPLACE (State or foreign country) <b>FLORIDA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>ELBERT McMATH</b>		14. MOTHER'S MAIDEN NAME <b>MILLIE THOMAS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>WW-1 545-18-1357</b>		17. INFORMANT Address <b>CLIN REC -VAH BALTIMORE MD-FT HOWARD DIVISION</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF THE PROSTATE WITH WIDE SPREAD METASTASIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>1772X</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 1</b> 19 <b>60</b> , to <b>April 8</b> 19 <b>60</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 8</b> 19 <b>60</b> , and that death occurred at <b>3:20 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE  <b>Charles Allen, M.D.</b> M.D. <b>CHARLES ALLEN, M.D.</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-9-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES ALLEN, M.D.</b>				22d. ADDRESS <b>VAH, BALTO. MD. FT. HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <input checked="" type="checkbox"/>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O Wilson</b>				25a. REC'D BY REGISTRAR DATE <b>APR 18 60</b>		25b. REGISTRAR'S SIGNATURE <b>C. L. S. Thomas</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**4226 CERTIFICATE OF DEATH**

64253

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. LENGTH OF STAY IN 1b <u>14 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1304 Poplar Ave.</u>				d. STREET ADDRESS <u>1304 Poplar Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George P.</u> Middle <u>Melchior</u> Last <u></u>				4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 12, 1893</u>		9. AGE (In years lost birthday) <u>67</u> yrs	10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Alcolec Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George P Melchior, Sr.</u>				14. MOTHER'S MARDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>215-18-8972</u>		17. INFORMANT <u>Edna M. Melchior</u> Address <u>1304 Poplar Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>Coronary artery disease</u> (b) <u>Arteriosclerosis</u> DUE TO <u></u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> 19 <u>60</u> , to <u>April 25</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>April 18</u> , 19 <u>60</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles R Shultz M.D.</u>				22b. DATE SIGNED <u>4-25-60</u>		22c. PHYSICIAN'S NAME (Type) <u>Charles R Shultz</u>	
22d. ADDRESS <u>1264 Francis Ave. Balto 27</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/28/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrose Inc. 1326 Sulphur Spring Rd</u>				25a. REC'D BY REGISTRAR DATE <u>APR 27 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



4315

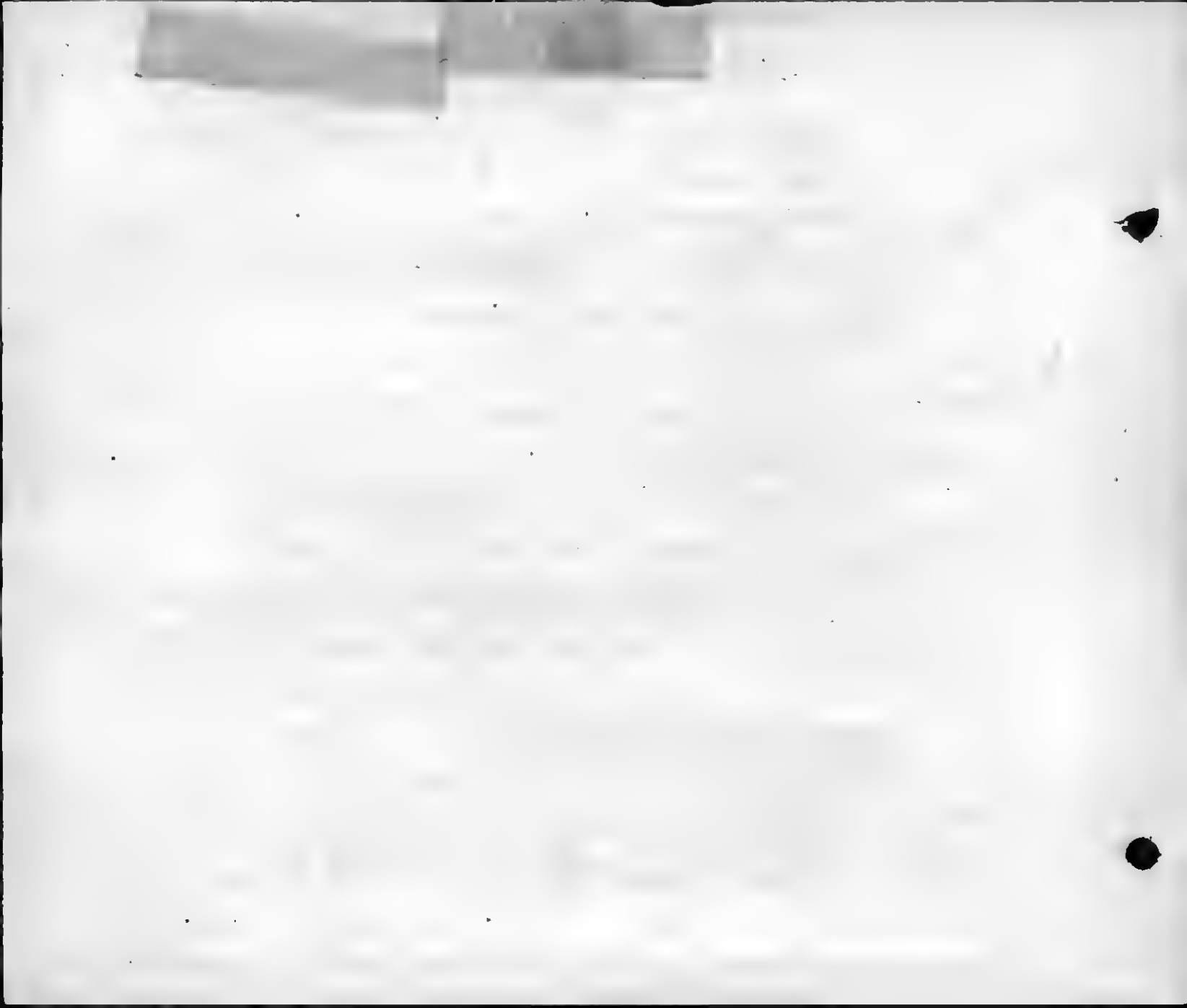
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Summit Nursing Home-98 Smithwood Ave.</b>				d. STREET ADDRESS <b>5803 Hillen Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>ROSA</b> Middle <b>LOUISE</b> Last <b>MERGENTHALER</b>				4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>1960</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 24, 1869</b>	9. AGE (In years last birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Jacob Heiss</b>				14. MOTHER'S MAIDEN NAME <b>Louise Marx</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Paul Mergenthaler - 5803 Hillen Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO <b>Degenerative Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cataracts Bilateral old, Fracture Nose, Catarrhs Artery, Sclerosis, Fracture Scapula</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>6 Mar 1955</b> to <b>27 April 1960</b> that I last saw the deceased alive on <b>27 April 1960</b> and that death occurred at <b>4:05 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W E McGloth M.D.</b>				ADDRESS (Street, city or town, state) <b>1303 Frederick Rd Catonsville 29nd</b>		DATE SIGNED <b>27 April 1960</b>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/29/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dread Ridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tinkner &amp; Sons - Balt. 17</b>				24a. REC'D BY REGISTRAR DATE <b>APR 29 1960</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton J. Kessler</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

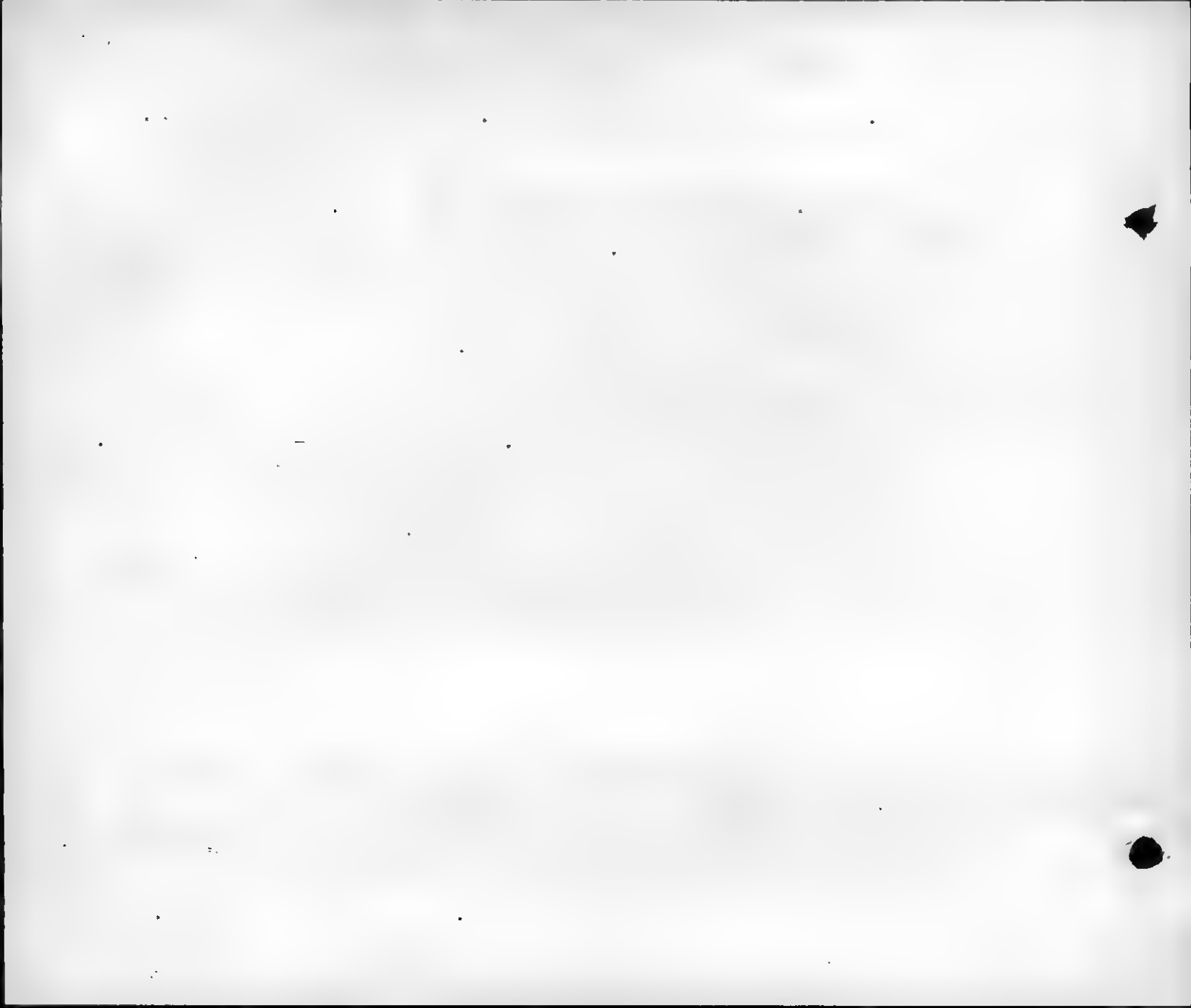


MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

4316

64255

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>527 Windwood Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FLORANCE</u> Middle <u>L.</u> Last <u>MEYRICK</u>				4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>60</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11/22/1896</u>	9. AGE (In years last birthday) <u>63</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Harry Shackelford</u>				14. MOTHER'S MAIDEN NAME <u>Estella Kimball</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Evelyn Kinsella - 527 Windwood Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420 1</u> DUE TO (b) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerotic cardiovascular disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-22</u> <u>1960</u> to <u>4-4</u> <u>1960</u> that (I) (we) last saw the deceased alive on <u>4-4</u> <u>1960</u> and that death occurred at <u>1:58</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Wm. H. Ossman Jr.</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>1101 St Paul St Balto 2 Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/7/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner &amp; Sons - Balto, Md</u>				25a. REC'D BY REGISTRAR DATE <u>APR 5 '60</u>		25b. REGISTRAR'S SIGNATURE <u>W. S. Kline</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04256

4317

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1835 White Oak Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Ella Margaret Merten</u>		4. DATE OF DEATH Month Day Year <u>April 12 19 60</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 21, 1865</u>
9. AGE (In years last birthday) <u>95</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Driscoll</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mrs. James Wunder</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO _____ (c) DUE TO _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>57</u> , to <u>4-11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-9</u> , 19 <u>60</u> , and that death occurred at <u>4 12</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>7122 Harford Road</u> DATE SIGNED <u>4/12/60</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Joseph Skloven</u>		<u>Baltimore, 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/15/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR DATE <u>APR 13 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

450.0

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4318

## CERTIFICATE OF DEATH

Reg. Dist. No.

64257

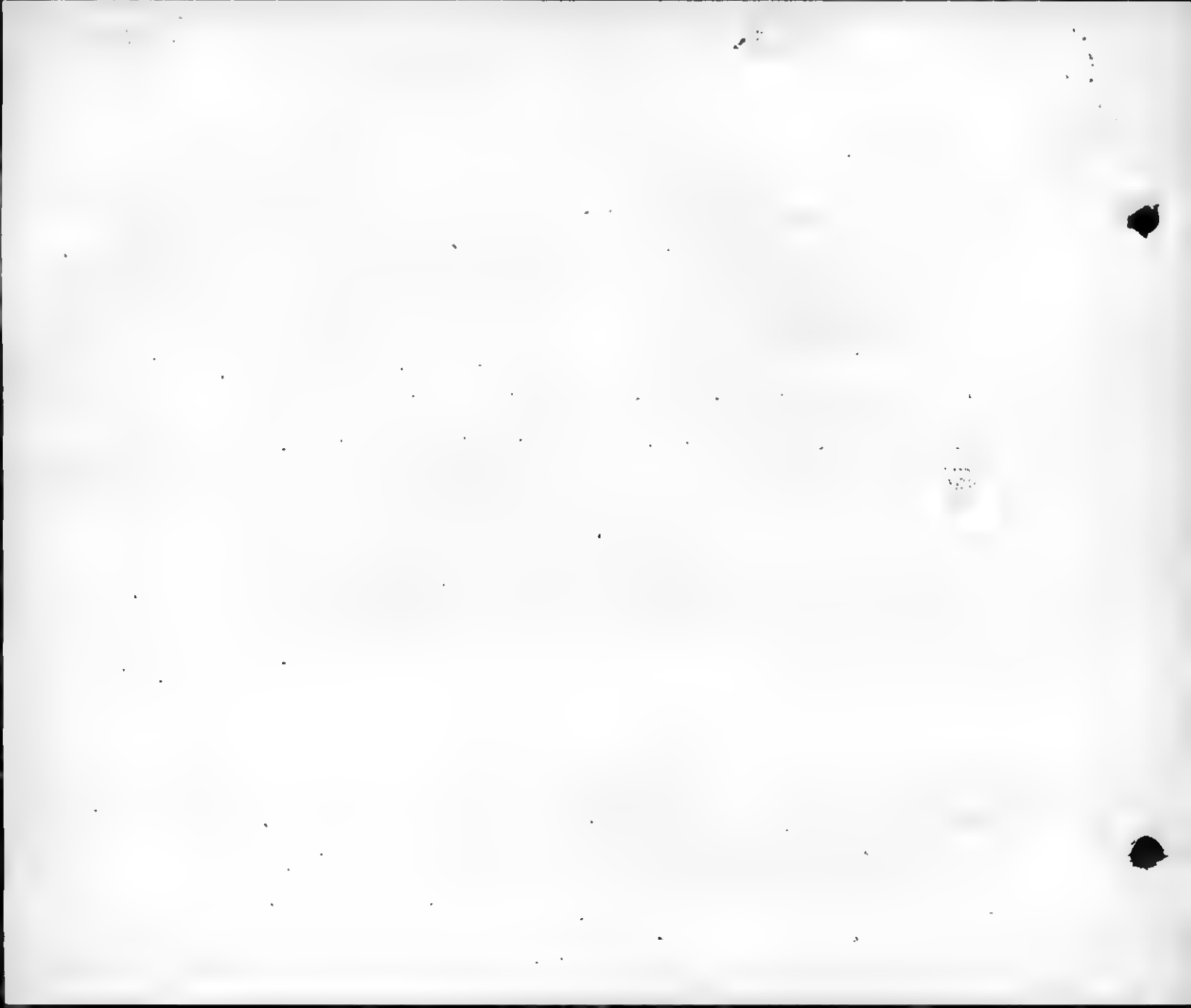
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE Manor</u> c. LENGTH OF STAY IN 1b <u>14 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1410 Dorchester Rd.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE Manor</u> d. STREET ADDRESS <u>1410 Dorchester Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Vernon</u> Last <u>MEUSHAW</u>		4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 16, 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>	11. UNDER 24 HRS Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STOREKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM MEUSHAW</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-28-3442</u>	
17. INFORMANT <u>MARYL MEUSHAW</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>SUDDEN DEATH -</u> DUE TO <u>PROGRESSIVE SCLEROTIC CARDIO-VASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>FRACTURE OF HIP - HEALING</u> DUE TO (c) <u>FRACTURE OF HIP - HEALING</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>10</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>deep in woods</u>		20f. (City or town) <u>Baltimore</u> (County) <u>Baltimore</u> (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>4/11</u> , 19 <u>60</u> , to <u>4/24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/24</u> , 19 <u>60</u> , and that death occurred at <u>10 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Shaw M.D.</u>		ADDRESS (Street, city or town, state) <u>5800 EDWARDS AVE</u>	
PHYSICIAN'S NAME (Type) <u>John H. Shaw M.D.</u>		DATE SIGNED <u>4/24/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-28-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) <u>BALTIMORE</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. E. Schwab</u>		24a. REC'D BY REGISTRAR <u>Francis W. Miller</u>	
24b. ADDRESS <u>2101 Frederick Ave</u>		24c. DATE <u>APR 27 '60</u>	
24d. REGISTRAR'S SIGNATURE <u>Arthur E. Hays</u>		24e. DATE <u>APR 27 '60</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/68



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4319

## CERTIFICATE OF DEATH

Reg. Dist. No.

04258

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WOODLAWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WOODLAWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6824 DOGWOOD RD.</u>		d. STREET ADDRESS <u>DOGWOOD RD.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOHANNA</u> First Middle Last <u>MEYERS</u>		4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 27 1863</u>
9. AGE (In years last birthday) <u>96</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN MEKINS</u>		14. MOTHER'S MAIDEN NAME <u>KEZIA SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>DAUGHTER NELLIE MEYERS</u> Address <u>6824 DOGWOOD RD. BALTO.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DEGENERATIVE HEART DISEASE</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERAL DEBILITY</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JANUARY 15, 1950</u> to <u>APRIL 13, 1960</u> , that I last saw the deceased alive on <u>APRIL 11, 1960</u> , and that death occurred at <u>1:55 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edwin L. Pierpont</u>		ADDRESS (Street, city or town, state) <u>8204 LIBERTY RD, BALTO. MD.</u> DATE SIGNED <u>4/13/60</u>	
PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/16/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>	22d. LOCATION (City, town, or county) (State) <u>Randalstown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. T. Stansbury</u> ADDRESS <u>6411 Windsor Mill Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 14 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

420.1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64259

4320

## CERTIFICATE OF DEATH

Reg. Dist. No.

32

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. LENGTH OF STAY IN 1b <b>30 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>48 Market Place</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>FRANCIS XAVIER MILLER</b>				<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>15</b> Year <b>1960</b>			
<b>5. SEX</b> <b>M</b>		<b>6. COLOR OR RACE</b> <b>W</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>11/1-1903</b>	
<b>9. AGE</b> (In years last birthday) <b>56 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <b>5</b> Days <b>10</b> Hours <b>15</b> Min. <b>00</b>		<b>IF UNDER 74 HRS.</b> Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>00</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Teacher</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Pennsylvania</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Francis Miller</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Annie Brown</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>				<b>16. SOCIAL SECURITY NO.</b> <b>216-01-131</b>		<b>17. INFORMANT</b> <b>Hospital Records, Mt. Wilson State Hospital</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>002X</b> DUE TO <b>Congestive Cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary infarction</b> DUE TO <b>Far advanced renal T. d. ...</b> (c) <b>Far advanced renal T. d. ...</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>12-24-57</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>				<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that I attended the deceased from</b> <b>10-24-37</b> <b>19</b> , to <b>4-15-</b> <b>1960</b> , that I last saw the deceased alive on <b>April 15, 1960</b> , and that death occurred at <b>4:15</b> M., from the causes and on the date stated above. <b>ADDRESS</b> (Street, city or town, state) <b>Mt. Wilson, Maryland</b> <b>DATE SIGNED</b>							
<b>ACTUAL SIGNATURE</b> <b>W. Newcomer</b>				<b>M.D.</b>			
<b>PHYSICIAN'S NAME</b> (Type) <b>Wm. Newcomer, M.D.</b>				<b>Superintendent</b>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>4/18/60</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Parkwood Cemetery</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Baltimore Co., Maryland</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. Brooks Bradley</b>				<b>ADDRESS</b> <b>Dundalk 22, Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>APR 18 '60</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Evans</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filled in by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1144





4321 CERTIFICATE OF DEATH

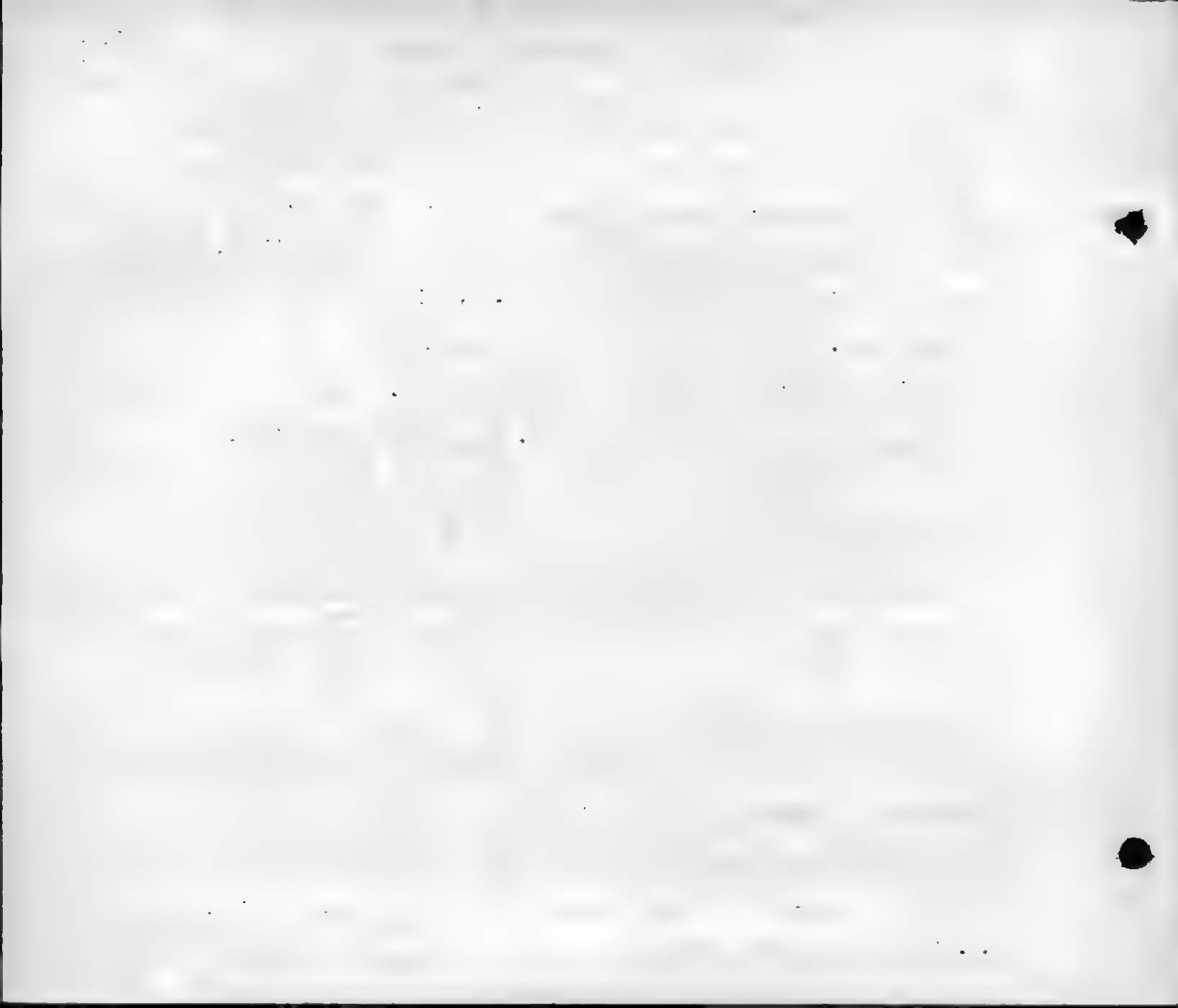
64260

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>57</b> <b>Catonsville</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2210 Westchester Ave.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>2210 Westchester Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROBERT BYRON MILLER</b> First Middle Last 4. DATE OF DEATH <b>April 22, 1960</b> Month Day Year		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Feb. 15, 1903</b> 9. AGE (In years last birthday) <b>57</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Doughnut Corp.</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Grays, Md</b> 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>William Miller</b> 14. MOTHER'S MAIDEN NAME <b>Nora C. Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO <b>215-10-5536</b> 17. INFORMANT <b>Mrs. Mary Miller, Catonsville, Md</b> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma, lung, metastatic</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>2-9</b> , 19 <b>60</b> to <b>4-22</b> , 19 <b>60</b> ; that I last saw the deceased alive on <b>4-16</b> , 19 <b>60</b> , and that death occurred at <b>11:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>46 Church Road</b> DATE SIGNED <b>4-22-60</b> ACTUAL SIGNATURE <b>Thomas F. Herbert, M.D.</b> PHYSICIAN'S NAME (Type) <b>Thomas F. Herbert, M.D.</b> <b>Ellicott City, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>4-25-60</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b> 22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham</b> ADDRESS <b>Ellicott City, Md</b> 24a. REC'D BY REGISTRAR <b>APR 25 60</b> DATE 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4322

## CERTIFICATE OF DEATH

Reg. Dist. No. 4261

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>8 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>207 Westshire Road</u>		d. STREET ADDRESS <u>207 Westshire Road</u>	
3. NAME OF DECEASED (Type or print) <u>FREDERICK S. MUMFORD</u>		4. DATE OF DEATH <u>April 27 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 6, 1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Snow Hill Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Eugene Mumford</u>		14. MOTHER'S MAIDEN NAME <u>Mary Maiden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>617-343667</u>	
17. INFORMANT <u>Lula L. Mumford</u>		Address <u>207 Westshire Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-renal-vascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>senility, cachexia, arterio-sclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 18, 1960</u> , to <u>April 27, 1960</u> , that I last saw the deceased alive on <u>April 26, 1960</u> , and that death occurred at <u>6:45 A.M.</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>L.C. Dobihal</u>		DATE SIGNED <u>4/27/60</u>	
PHYSICIAN'S NAME (Type) <u>L.C. Dobihal, M.D.</u>		ADDRESS (Street, city or town, state) <u>447 N. Kenwood Ave.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial April 30 1960</u>	<u>April 30 1960</u>	<u>Landon Park</u>	<u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Tempel</u>		24a. REC'D BY REGISTRAR <u>APR 29 '60</u>	
ADDRESS <u>5311 Edmondson Ct</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**4323** **CERTIFICATE OF DEATH**

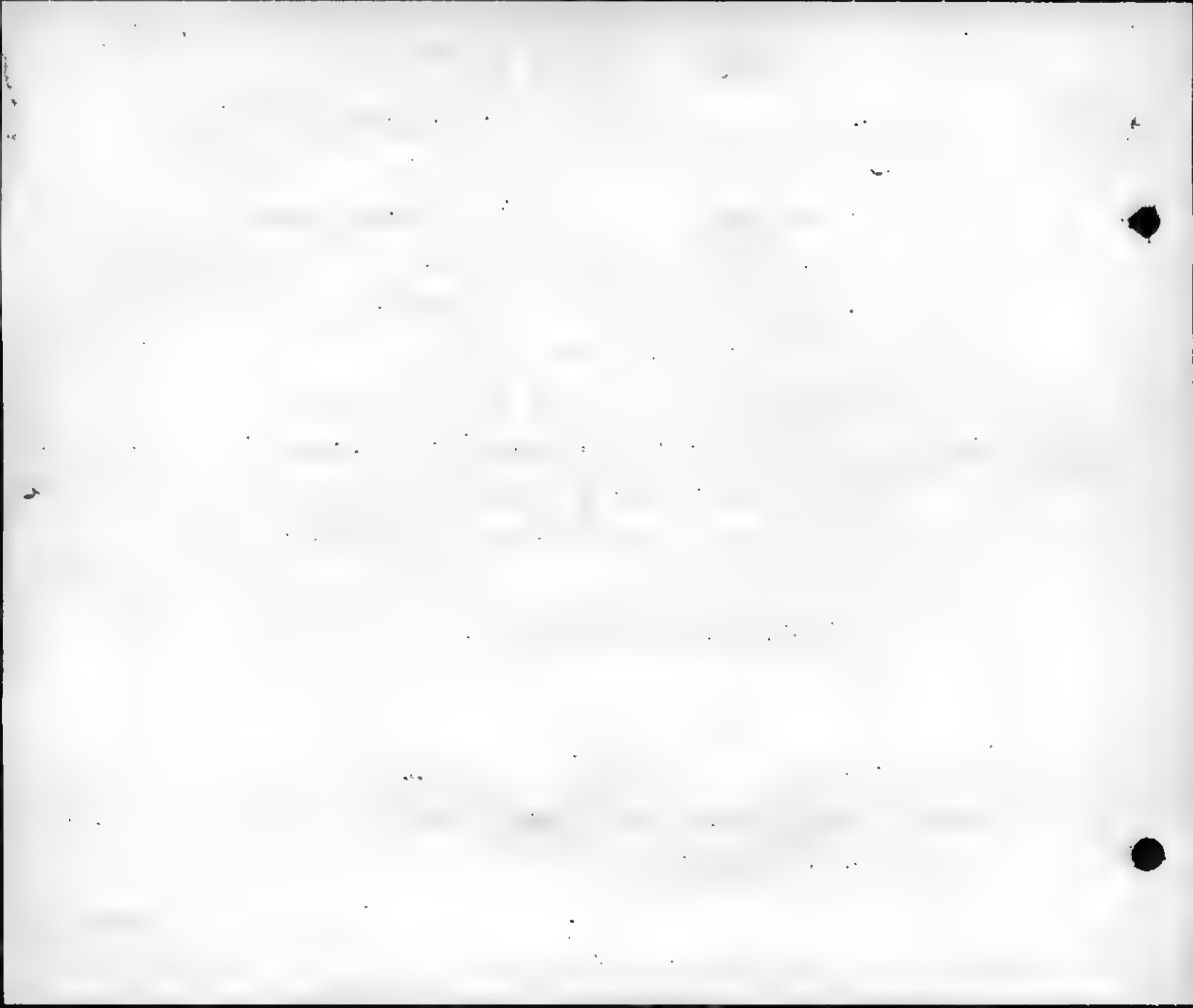
04262

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Balto.</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7425 Kenlea Ave.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bivalve</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>EZEKIEL S MURPHY</b>				<b>4. DATE OF DEATH</b> <b>April 9, 1960</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Sept. 7, 1872</b>	
<b>9. AGE</b> (In years last birthday) <b>87</b> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				<b>13. FATHER'S NAME</b> <b>John Murphy</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>?</b>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes no, or unknown) <b>No</b>			
<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <b>Mrs. Frank Seiler- 7425 Kenlea Ave. Balto. 6, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.0</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) _____ <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>Urinary obstruction due to prostatic hypertrophy</b>							
<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 hrs</b> <b>20 yrs.</b>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>							
<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from 3 - 2 - 1960 to 4 - 7 - 1960, that (I) (we) last saw the deceased alive on 4 - 9 - 1960, and that death occurred at 1:30 PM, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Santi Amoroso</b>				<b>22b. DATE SIGNED</b> <b>4-9-1960</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Amorosa</b>				<b>22d. ADDRESS</b> <b>6811 Belton Rd Balto 6 Md</b>			
<b>23a. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>4/12/1960</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Bivalve Church Cemetery</b>		<b>23d. LOCATION (City, town, or county)</b> (State) <b>Bivalve, Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>C. H. Messick - Bivalve, Md.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>APR 12 '60</b>			
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Clarence S. Frank</b>							

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. **Titan** please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

450.8





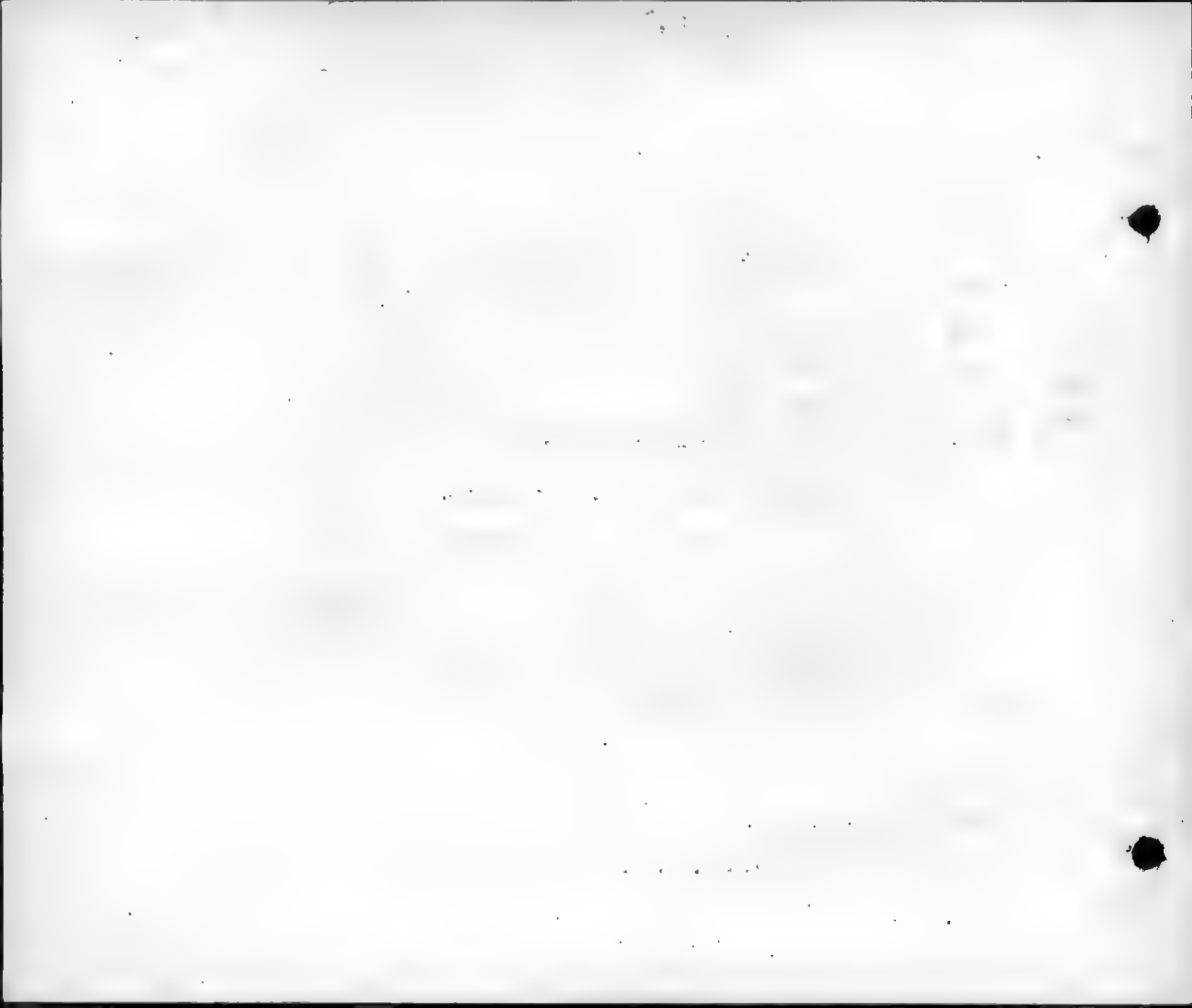


4325

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>C tonsville</b>		c. LENGTH OF STAY IN 1b <b>11yr2mth6dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOS TAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Laurence</b> Middle _____ Last <b>O'Donnell</b>		4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 1893</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>shipyard worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John O'Donnell</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Geissler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO <b>220-18-6667</b>	
INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gangrene of the left foot</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 16, 1960</b> to <b>April 3, 1960</b> , that I last saw the deceased alive on <b>April 3, 1960</b> , and that death occurred at <b>7:15p</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>4-4-60</b>			
ACTUAL SIGNATURE <b>Stella Wachler</b>		M.D. <b>SPRING GROVE STATE HOSPITAL</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachler, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4-20-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>WESTERN CEM</b>	22d. LOCATION (City, town, or county) (State) <b>EDMONDSON AVE. BALTO. MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles J. Seiler</b>		24a. REC'D BY REGISTRAR DATE <b>APR 21 '60</b>	
ADDRESS <b>6224 EASTERN AVE. BALTO. MD</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kincaid</b>	



Reg. Dist. No. 4265

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 21, 60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>	22d. LOCATION (City, town, or county) <b>Pikeville, Md.</b>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.T.Stansbury</b>		ADDRESS <b>6411 Windsor Mill Road</b>	24a. REC'D BY REGISTRAR <b>DATE APR 21 '60</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>

VS A15 (4)  
15M 10/57



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

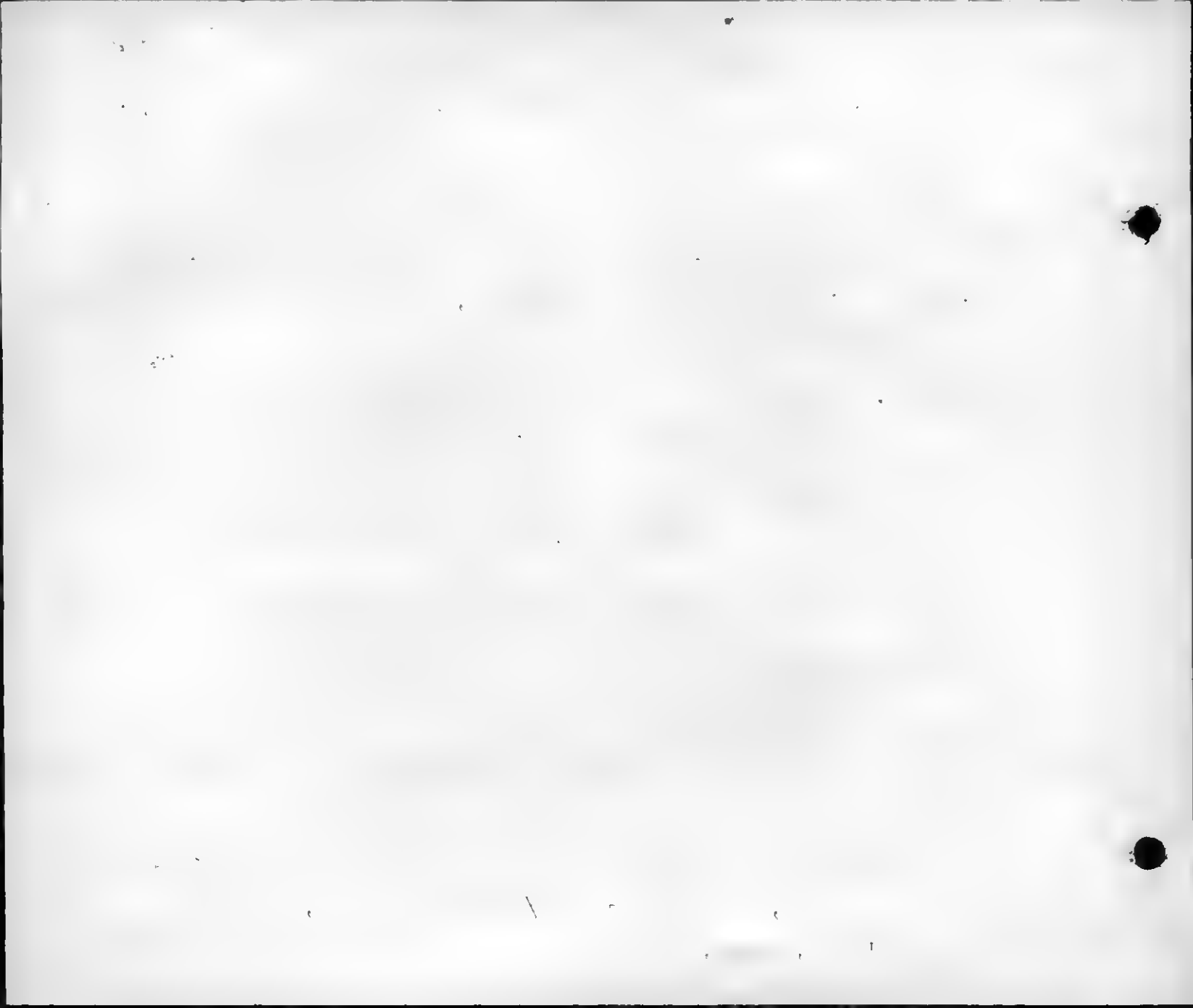
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

64266

4327

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>625 York Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LOUISE REBECCA PARKS</b>				4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1869</b>	9. AGE (In years last birthday) <b>91</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Never employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel E. Parks</b>				14. MOTHER'S MAIDEN NAME <b>Martha Lee</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Family Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Decompensative Cardio Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>JUNE 10, 1957</b> to <b>April 6, 1960</b> that (I) (we) last saw the deceased alive on <b>April 6, 1960</b> , and that death occurred at <b>8 AM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>Laurence C. Post</b>				22b. DATE <b>4-7-60</b>		22c. PHYSICIAN'S NAME (Type) <b>LAURENCE C. Post</b>	
22d. ADDRESS <b>6805 York Rd. Baltimore 12 Md</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 9, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Towson, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>APR 11 '60</b>		25b. REGISTRAR'S SIGNATURE <b>John S. Burns</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4328

## CERTIFICATE OF DEATH

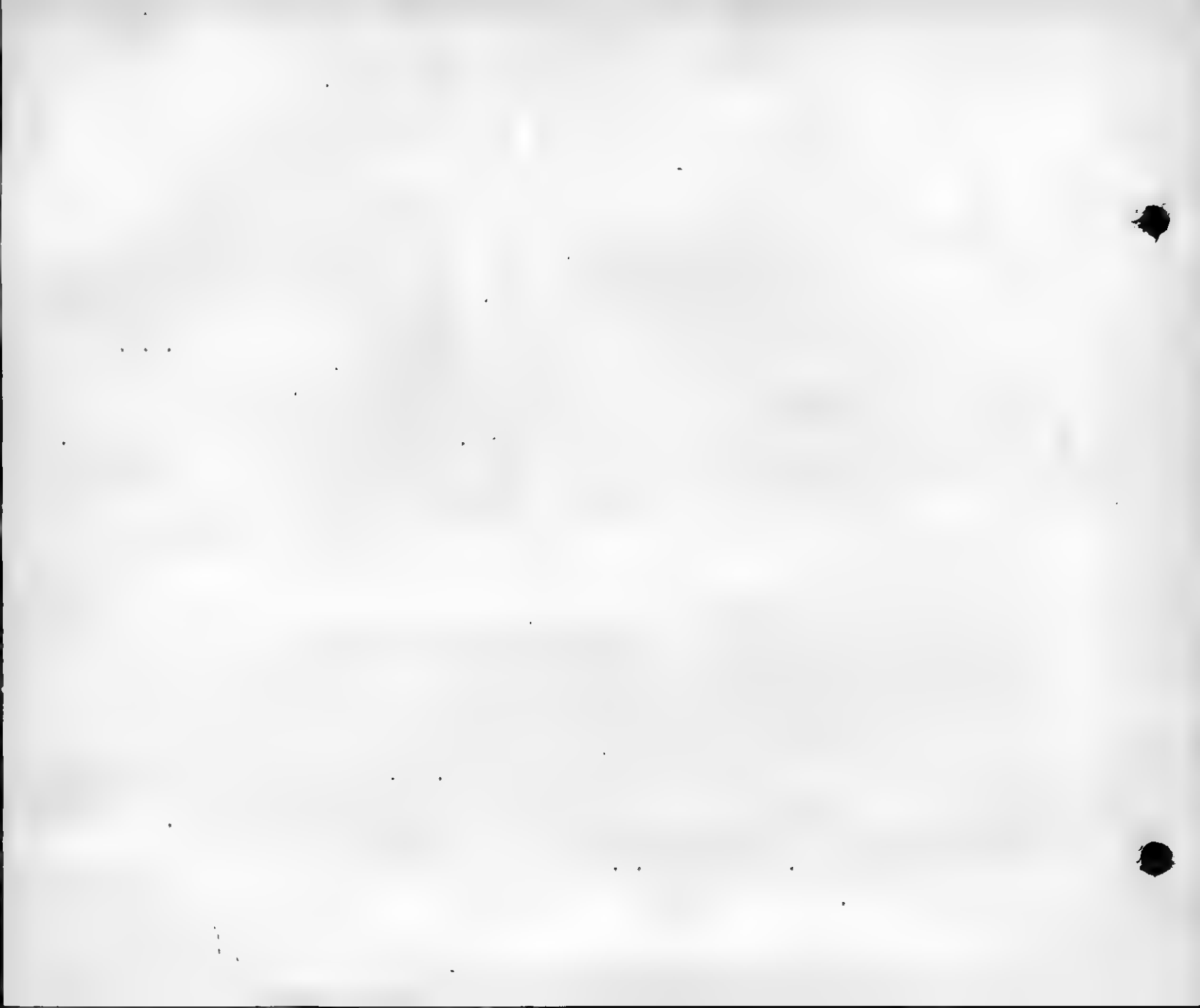
Reg. Dist. No.

04267

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Bald</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenarm Road</b>		/d. STREET ADDRESS <b>Glenarm Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sister Mary Amatora Pfeufer</b>		4. DATE OF DEATH Month Day Year <b>April 24 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 16, 1875</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Bavaria</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Henry Pfeufer</b>	
14. MOTHER'S MAIDEN NAME <b>Gertrude Steigerwald</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT <b>Sister M. Peter Fourier</b> Address <b>Notch Cliff, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>(b)</b> DUE TO lying cause (c) <b>(c)</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 10</b> , 19 <b>56</b> , to <b>April</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>April 19</b> , 19 <b>60</b> , and that death occurred at <b>6:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7501 York Road Towson 4, Md.</b> DATE SIGNED <b>4/24/60</b>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell M.D.</b>			
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/26/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Villa Maria Cemetery</b>	22d. LOCATION (City, town or county) (State) <b>Notch Cliff Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Zeiler</b> ADDRESS <b>6224 Eastern Ave Baltimore</b>		24. REC'D BY REGISTRAR DATE <b>APR 27 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# 1 4 M X 1 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 10/57 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

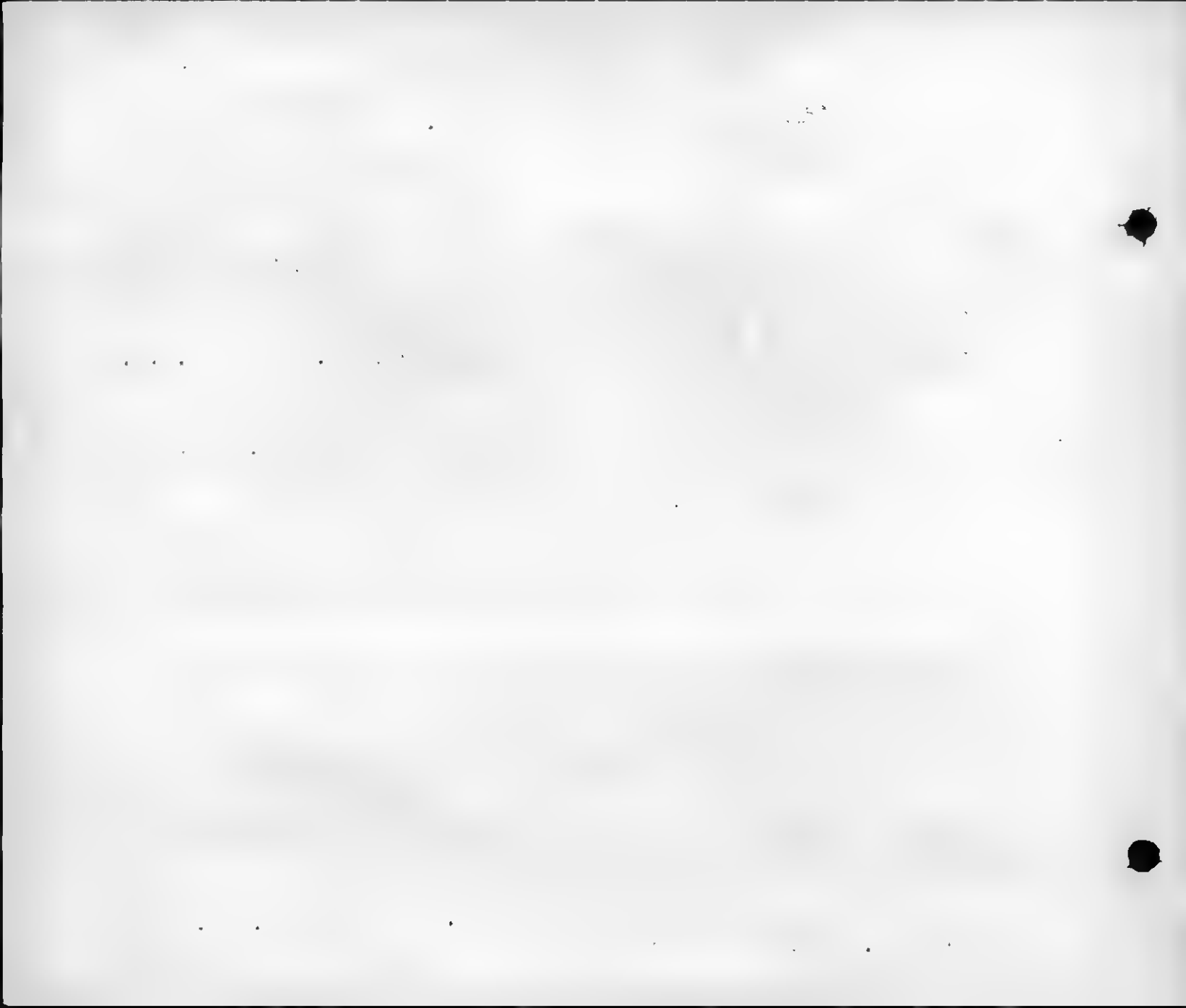
64268

4329

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Owings Mills</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9 Kingsley</b>		e. STREET ADDRESS <b>9 Kingsley</b>	
3. NAME OF DECEASED (Type or print) <b>FRANK PICHA</b>		4. DATE OF DEATH <b>April 23 19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/20/1892</b>
9. AGE (In years last birthday) <b>67</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ret-Police</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Picha</b>		14. MOTHER'S MAIDEN NAME <b>Anna Barborka</b>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Jeanette Forrest Picha, wife, above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>15 months</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1960</b> to <b>April 23, 1960</b> , that I last saw the deceased alive on <b>April 23, 1960</b> , and that death occurred at <b>7:40 A.M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Charles E. Schimunek</b> M.D. <b>11904 Kirtistown Rd Kirtistown Md April 23/1960</b>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/26/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Com.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Schimunek Funeral Home</b>		24a. REC'D BY REGISTRAR <b>DATE Apr 26 '60</b>	
2331 Brehms Lane		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



## CERTIFICATE OF DEATH

4330

Item 9 FilmG263 5-20-60 et

Reg. Dist. No. 04269 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore County</u>				STATE <u>Maryland</u> COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Mt. Wilson, Maryland</u>				TOWN <u>Baltimore City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>5902 Enrich Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>DAVIS</u> (Middle) <u>BOYD</u> (Last) <u>PLUMLEE</u>				(Month) <u>April</u> (Day) <u>15</u> (Year) <u>1960</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS
<u>M</u>	<u>W</u>	<u>X</u>	<u>7-6-188</u>	<u>71</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Furniture Finisher</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
						<u>Knoxville, Tenn.</u>	
13. FATHER'S NAME <u>Joseph Plumlee</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <u>X</u>				16. SOCIAL SECURITY NO. <u>413-05-0964</u>		17. INFORMATION & ADDRESS	
(If Yes, give war or dates of service)						<u>Hosp. Records, Mt. Wilson State Hospital</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pulmonary insufficiency</u>						<u>7-18-58</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary Emphysema</u>						<u>to</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Pulmonary Tuberculosis</u>						<u>4/15/60</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-18-58</u> 19....., to <u>4-15-60</u> 19....., that I last saw the deceased alive on <u>4-15</u> 19....., and that death occurred at <u>1:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. Newcomer</u>				ADDRESS (Street, city, town, state) <u>M.D. Superintendent, Mt. Wilson, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>4-20-60</u>		NAME OF CEMETERY OR CREMATORY <u>Green Valley Burial</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>William P. Kiser</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Hamble</u>		ADDRESS <u>Parkville, Md.</u>	
DATE <u>APR 22 '60</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been examined by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4331  
CERTIFICATE OF DEATH

04270

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mass.</b> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>				c. LENGTH OF STAY IN 1b <b>2½ years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Bedford</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cuba Road (Rural)</b>				d STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALFRED</b> Middle <b>ROBERT</b> Last <b>POPP</b>				4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>1960</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 18, 1886</b>			
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Metal Polisher-ret.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Jewelry Factory</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>									
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Family Records</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>181.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PNEUMONIA - LEFT LOWER LOBE</b> DUE TO (c) <b>CARCINOMATOSIS - BLADDER</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>GENERALIZED ARTERIOSCLEROSIS</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 DAY</b> <b>5 DAY</b> <b>5 YRS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour <b>0</b> m <b>19</b> p m				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>Westport, Mass.</b>				(County) <b>Westport, Mass.</b>		(State) <b>Mass.</b>			
21 I certify that (1) (this hospital) attended the deceased from <b>4-8-60</b> to <b>4-10-60</b> that (2) (we) last saw the deceased alive on <b>4-9-60</b> , and that death occurred at <b>7:30</b> AM, from the causes and on the date stated above.									
22a. SIGNATURE <b>Donald O. Wood, M.D.</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>4-10-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>DONALD O. WOOD, M.D.</b>				22d. ADDRESS <b>204 QUAKER RIDGE RD - TIMONUM MD</b>					
23. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>April 15, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>May Flower Cemetery</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>				ADDRESS <b>Towson, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 12 '60</b>			
				25b. REGISTRAR'S SIGNATURE <b>William S. Frank</b>					

181.0

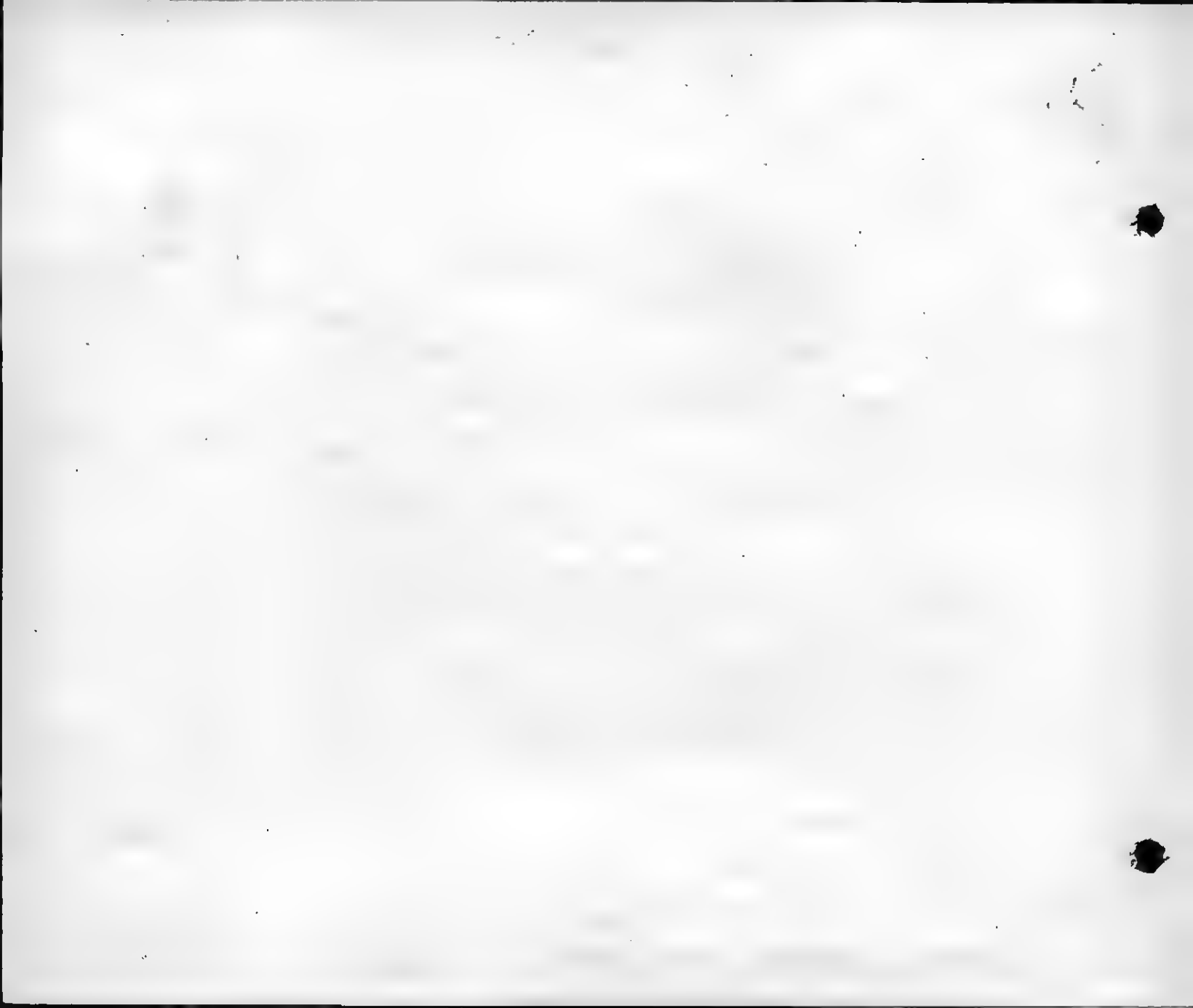
4332

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>34</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines</u>		e. STREET ADDRESS <u>Marlborough Apt</u>		
3. NAME OF DECEASED (Type or print) <u>Minnie</u> First <u>Quitt</u> Middle <u>Quitt</u> Last		4. DATE OF DEATH <u>4-26-1960</u> Month <u>4</u> Day <u>26</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>	
9. AGE (In years <u>77</u> yrs.)	IF UNDER 1 YEAR <u>77</u> Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Raphael Ellison</u>		14. MOTHER'S MAIDEN NAME <u>Hattie unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>unknown</u>		
17. INFORMANT <u>Elliot Deane</u> Address <u>Tower Bldg</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Cerebral Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Hypertensive Cardio Vascular Disease</u> DUE TO <u>Hypertensive Cardio Vascular Disease</u> (b) <u>about</u> (c) <u>a month</u> <u>5 or 6 years</u> <u>about 5 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>about</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/31</u> , 19 <u>42</u> to <u>4/26</u> , 19 <u>60</u> that I last saw the deceased alive on <u>4/16</u> , 19 <u>60</u> , and that death occurred at <u>10 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>11 E Chase St, Balto Md</u> DATE SIGNED <u>4/27/60</u>				
ACTUAL SIGNATURE <u>Theodore H. Morrison</u> M.D.		PHYSICIAN'S NAME (Type) <u>Theodore H. Morrison</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>4-28-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>	22d. LOCATION (City, town, or county) (State) <u>Balt Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>3100 Eutan Pl</u>		24a. REC'D BY REGISTRAR <u>APR 28 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death may be required by the hospital or attending physician.





## 4333 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-RANDALLSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-RANDALLSTOWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 305 RT. 5 Windsor Mill Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ALBERT L. Reeb</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 13-1914</u>		9. AGE (In years last birthday) <u>45</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AUTO. MECHANIC</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John C. Reeb</u>				14. MOTHER'S MAIDEN NAME <u>CZLLA HOWARD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-10-5900</u>		17. INFORMANT <u>Box 305 RT. 5 MRS. Millie T. Reeb</u>		Address <u>Windsor Mill Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CLONING INSUFFICIENT</u> DUE TO (c) <u>100%</u>						INTERVAL BETWEEN ONSET AND DEATH <u>420-1</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>FEB. 15, 1960</u> to <u>APRIL 15, 1960</u> , that I last saw the deceased alive on <u>APRIL 15, 1960</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Edwin J. Piez...</u> M.D. <u>8204 E. ...</u>				<u>4/29/60</u>			
PHYSICIAN'S NAME (Type) <u>Edwin J. Piez...</u>				<u>BALTIMORE MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 28, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Turner Schuch</u>				ADDRESS <u>3512 Frederick Ave. (29)</u>		24a. REC'D BY REGISTRAR DATE <u>APR 28 60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

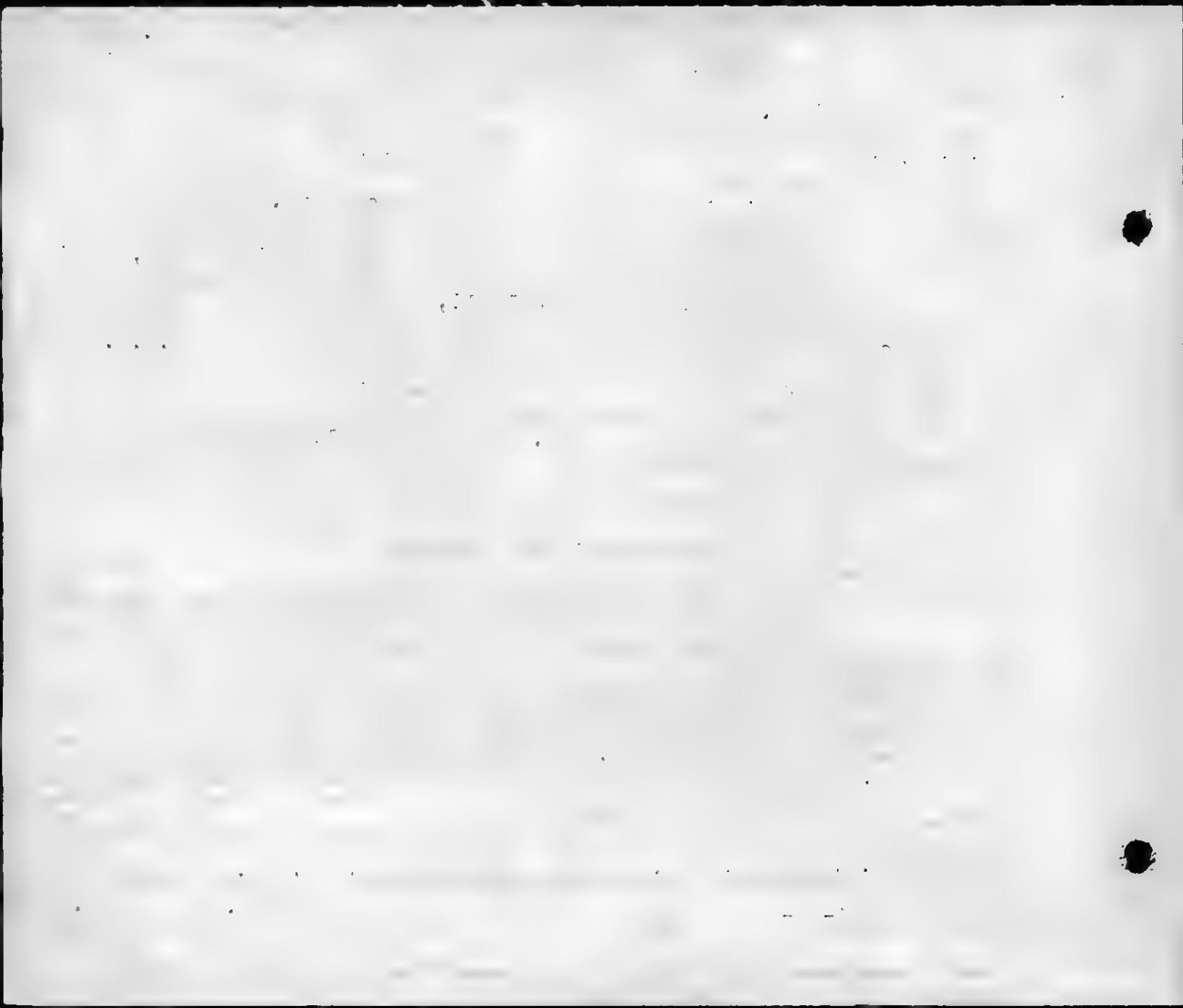
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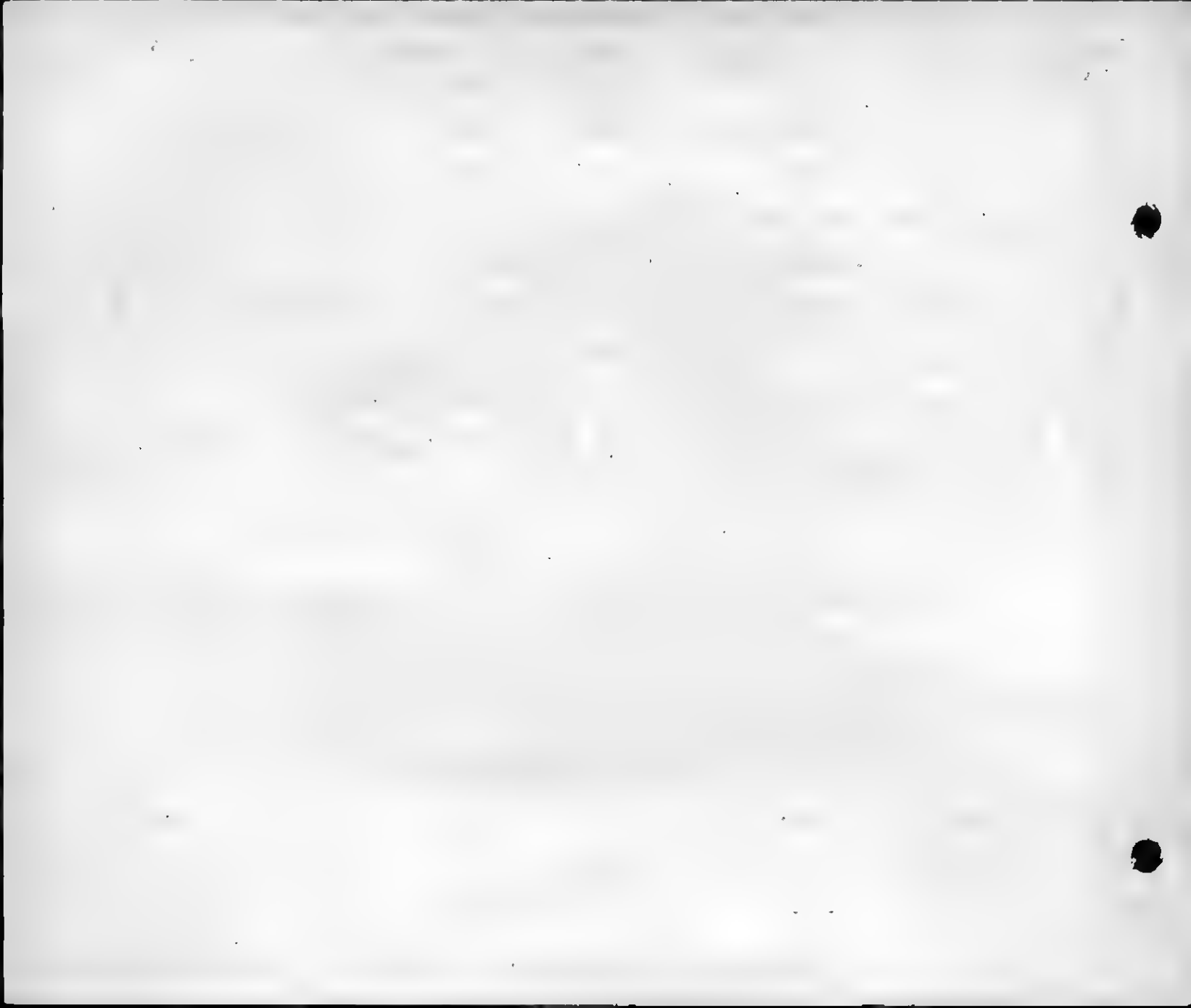
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>52 Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>17 Melrose Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Eora</b> First <b>Rheubottom</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 13, 1883</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Bond</b>		14. MOTHER'S MAIDEN NAME <b>Annie Hall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Thomas Ryan</b> Address <b>17 Melrose Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mitral Insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive-arterio-sclerotic Heart Disease</b> DUE TO (c) <b>Hypertrophic Arthritis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>100 Days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertrophic Arthritis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 15th, 1960</b> , to <b>Apr 24th, 1960</b> , that I last saw the deceased alive on <b>Apr. 24th, 1960</b> , and that death occurred at <b>11 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>57 Winters Lane</b> DATE SIGNED <b>4/25/60</b>			
ACTUAL SIGNATURE <b>C. F. Maloney M.D.</b>		PHYSICIAN'S NAME (Type) <b>C. F. Maloney, M.D.</b> <b>Catonsville, 28. Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-27-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Western Star Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Catonsville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. H. ...</b> ADDRESS <b>578 ...</b>		24a. REC'D BY REGISTRAR DATE <b>APR 26 '60</b>	24b. REGISTRAR'S SIGNATURE <b>...</b>







## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4227' CERTIFICATE OF DEATH

64275  
Reg. Dist. No.

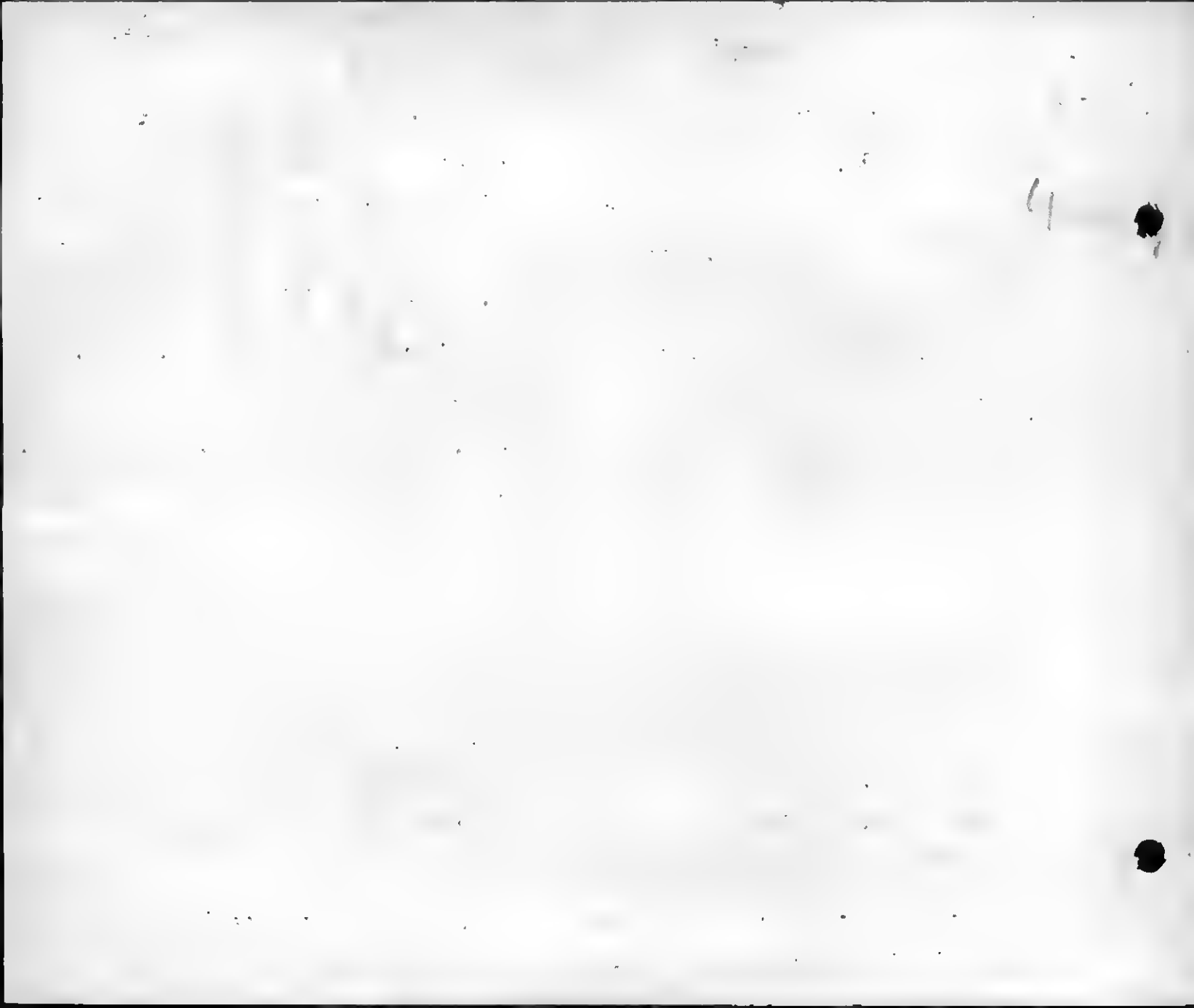
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Relay</b>				c. LENGTH OF STAY IN 1b <b>5/Relay</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1725 Arlington Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Henry W.</b> Middle <b>Routenberg</b> Last <b></b>				4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>1960</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 2, 1885</b>	
9. AGE (In years less birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b>		IF UNDER 24 HRS Hours <b></b> Min <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O</b>		11. BIRTHPLACE (State or foreign country) <b>Michigan</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
INFORMANT <b>Bertha E. Routenberg</b>				Address <b>1725 Arlington Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary thrombosis</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Artery Disease</b>							
(c) <b>Unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Sept</b> , 19 <b>58</b> , to <b>April 14</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>April 14</b> , 19 <b>60</b> , and that death occurred at <b>8:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James J. Nolan</b>				ADDRESS (Street, city or town, state) <b>1 Malver Hill Ave., Baltimore 29, Md.</b>			
PHYSICIAN'S NAME (Type) <b>J. J. NOLAN</b>				DATE SIGNED <b></b>			
22a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/16/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>				ADDRESS <b>4107 Wilkens</b>		24a. REC'D BY REGISTRAR <b>APR 18 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>			

1  
5-2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

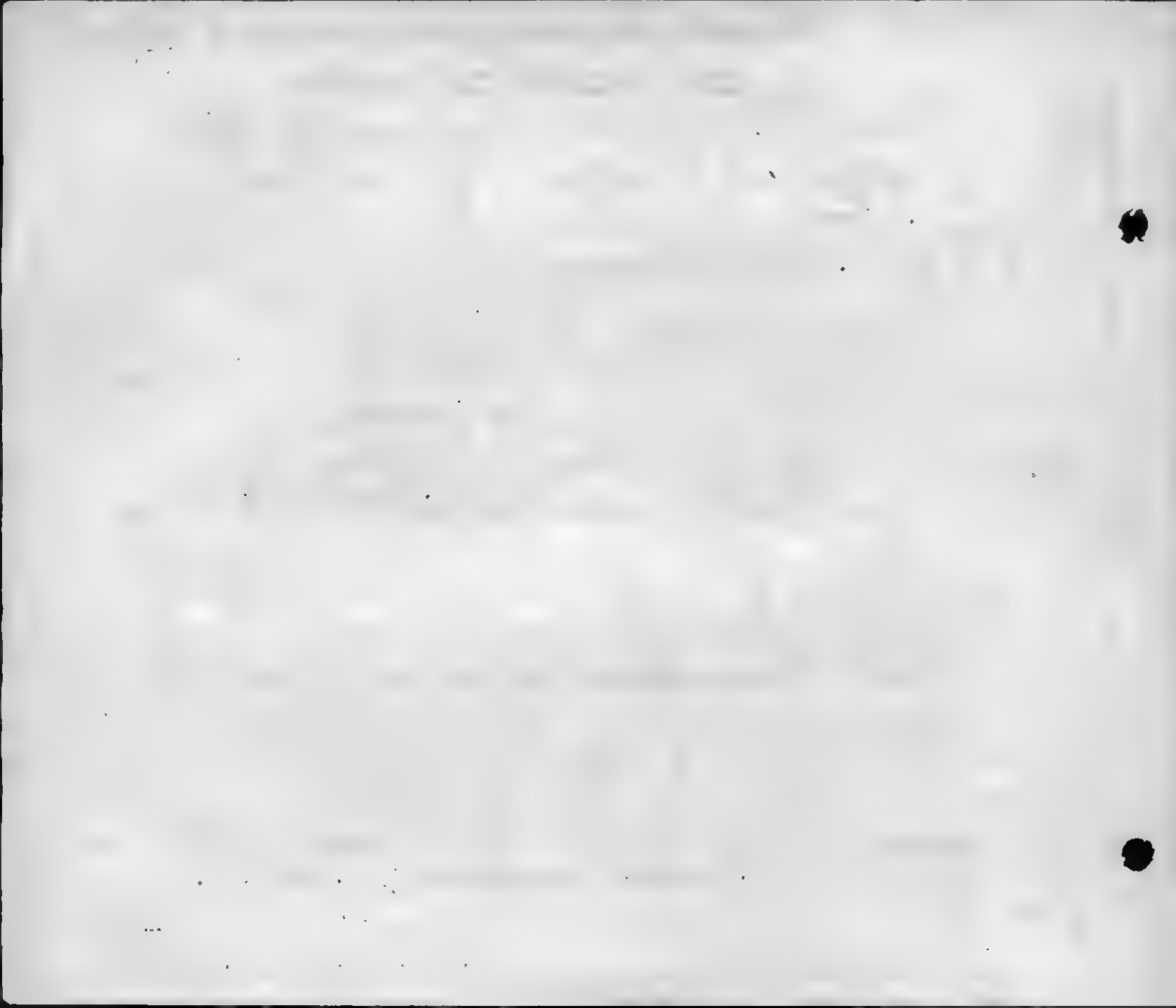
4276

## CERTIFICATE OF DEATH

4335

Reg. Dist. No. 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Carroll</u> ✓			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Wilson</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Finksburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>R.D. #1</u>			
3. NAME OF DECEASED (Type or Print) <u>HAZEL ELIZABETH SCHAEFER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 25 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 5 1892</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New Orleans La.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN HUTH</u>				14. MOTHER'S MAIDEN NAME <u>ROSE HERR</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>104-095264</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
005X IMMEDIATE CAUSE (A) <u>Congestive Cardiac failure.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4/18/60</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary fibrosis &amp; Emphysema.</u>				<u>Till</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Pulmonary Tuberculosis</u>				<u>4/25/60</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-18</u> , 19 <u>60</u> , to <u>4-25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-25</u> , 19 <u>60</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. Newcomer</u>				ADDRESS (Street, city, town, state) <u>M.D. Superintendent, Mt. Wilson, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		DATE THEREOF <u>4-27-60</u>		NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		LOCATION (City, town, or county) (State) <u>Baltimore</u>	
24. REC'D BY REGISTRAR DATE <u>APR 28 '60</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Kious</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>		ADDRESS	



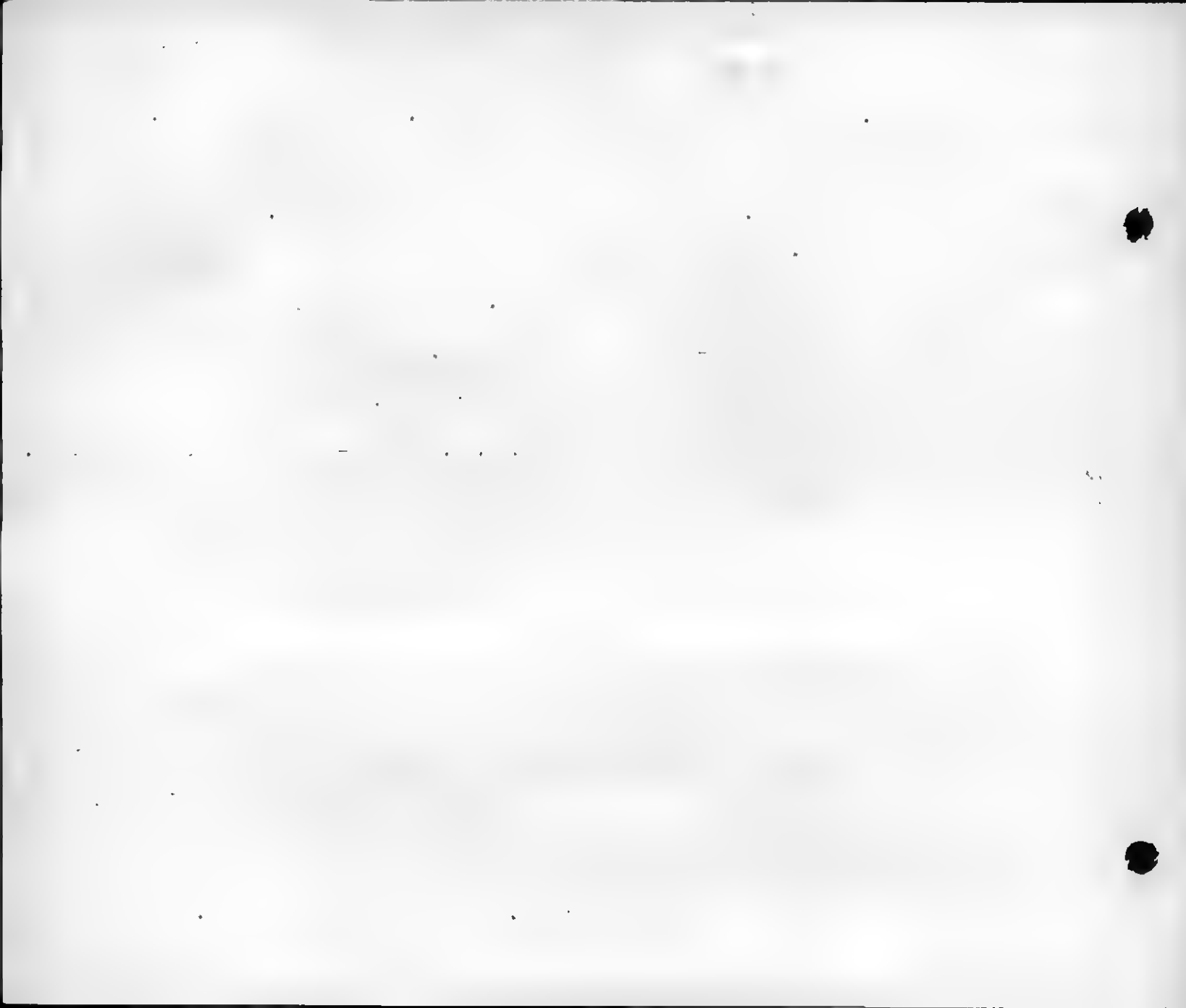
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

4336

04277

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>A. A.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Louison - 4</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7603 Knollwood Rd.</b>				d. STREET ADDRESS <b>101 Farragut Rd.</b>			
3. NAME OF DECEASED (Type or print) <b>L. First DULCIE Middle Lost SCHLEY</b>				4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>1960</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 14, 1887</b>	9. AGE (In years lost birthday) yrs. <b>73</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Reverty Browning</b>				14. MOTHER'S MAIDEN NAME <b>Sarah E. Purdum</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. J. W. Schley - City Market, Annapolis, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis (Recurrent)</b> DUE TO (b) <b>Arterio-Sclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b> <b>5 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 15, 1960</b> to <b>April 29, 1960</b> that (I) (we) last saw the deceased alive on <b>April 27, 1960</b> , and that death occurred on <b>April 29, 1960</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Earl L. Chambers</b>				22b. DATE SIGNED <b>4-30-60</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. EARL L. CHAMBERS</b>	
22d. ADDRESS <b>4108 LIBERTY HEIGHTS AVE</b>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> MED. STAFF <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/2/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Treloar &amp; Sons - Wash 17</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 2 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	



1

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

64278

4337

1. PLACE OF DEATH a COUNTY <b>Baltimore</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrison</b>				c LENGTH OF STAY IN 1b			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Foxleigh Nursing Home</b>				e STREET ADDRESS <b>8300 Marcia Drive</b>			
3. NAME OF DECEASED (Type or print) <b>Toney</b> First <b>Schloss</b> Last				4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1960</b>			
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 10, 1882</b>	9 AGE (In years last birthday) <b>77</b> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>lumber</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Abraham Schloss</b>			14. MOTHER'S MAIDEN NAME <b>Sophia Schlufsky</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Jerry Schloss- 8300 Marcia Drive</b> Address			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Emphysema, Exacerbated</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>2 hr</b> <b>15 yr</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c TIME OF INJURY Month, Day, Year Hour a m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>July 1937</b> to <b>April 21, 1960</b> that (I) (we) last saw the deceased alive on <b>April 21, 1960</b> , and that death occurred at <b>9:15 AM</b> , from the causes and on the date stated above							
22a SIGNATURE <b>Joseph B Gross</b>				22b DATE SIGNED		22c PHYSICIAN'S NAME (Type) <b>Joseph B Gross</b>	
22d ADDRESS <b>6911 Paul Street, Baltimore, Md.</b>		22e. MED. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr 25/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hebrew Friendship</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Sol. Levinson &amp; Bros. Inc. 6010 Reist. Rd.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 26 1960</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse in certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

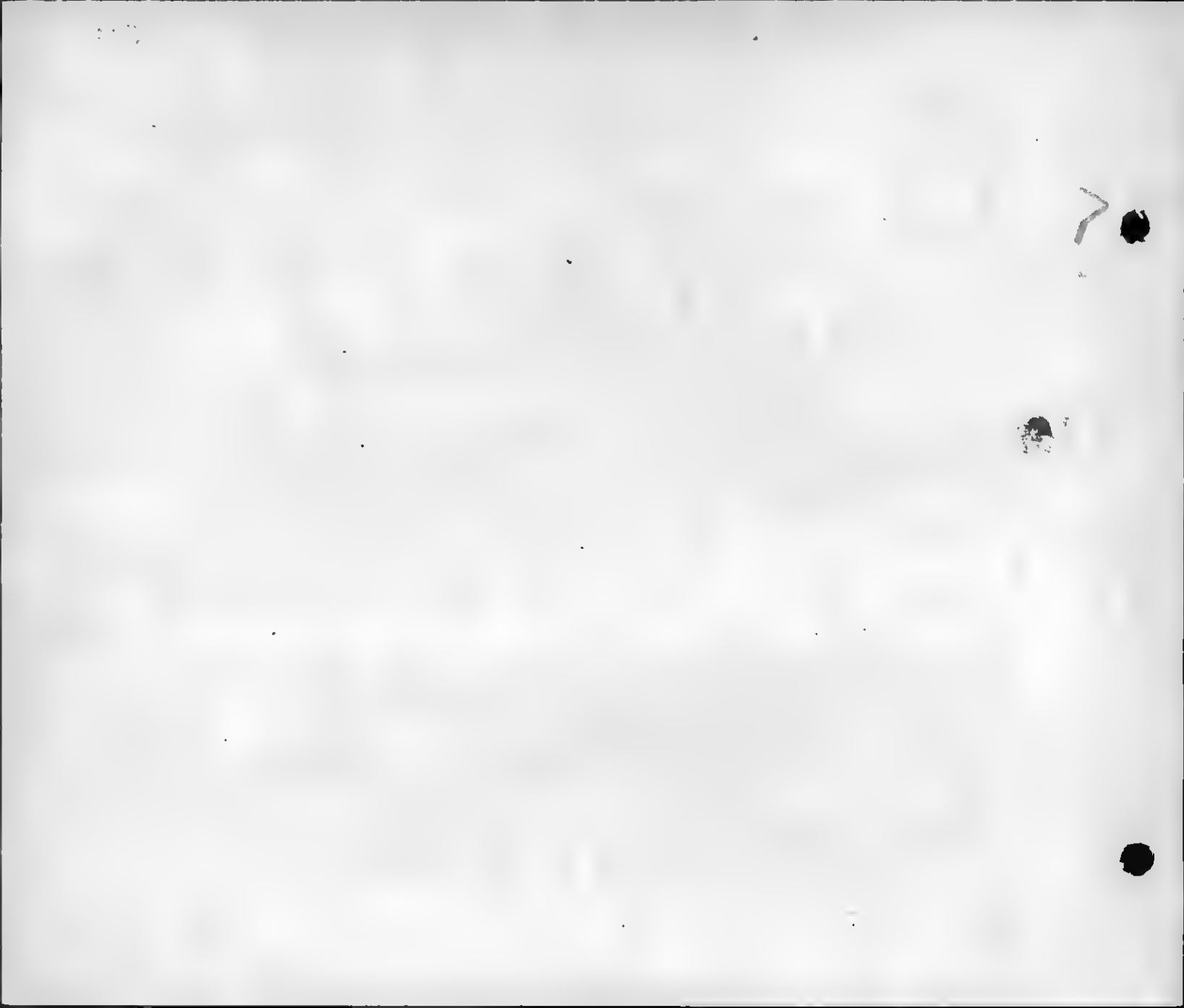
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4333 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64279

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>				c. LENGTH OF STAY IN 1b <b>16 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>117 N. MARLYN AVE. Balto 21</b>				d. STREET ADDRESS <b>357 Charles Ave. (21)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN SCHNEIDER</b>				4. DATE OF DEATH Month Day Year <b>APR. 24 1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-23-76</b>	9. AGE (In years last birthday) <b>84 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>GERMANY</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A</b>		
13. FATHER'S NAME <b>SCHNEIDER</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Minnie Jungblut 117 N. Marlyn Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause pertaining for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arterio. Scler.</b> DUE TO <b>Emphysema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Emphysema</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral indirect inguinal hernia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>20 years</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Jack C Collins</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4-25-60</b>			
EXAMINER'S NAME (Type) <b>JACK C COLLINS</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4-27-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. CO. MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John V. Connolly 418 Eastern Bldg.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and must be presented within 72 hours after death.

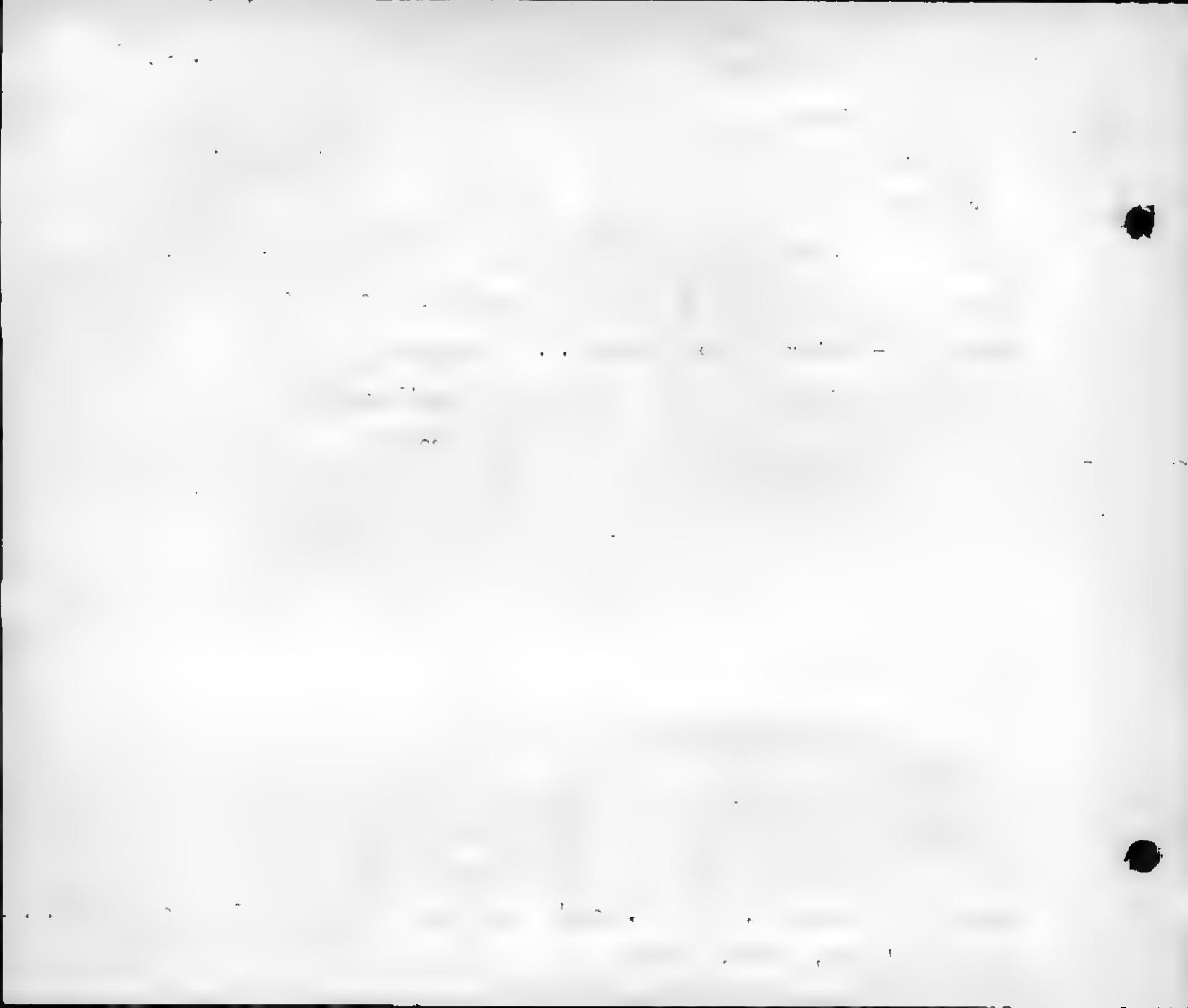
VR A15 (4)  
15M 9/59

1  
2

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4339 CERTIFICATE OF DEATH

64280

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Richmond Hills</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Codd Nursing Home</b>				d. STREET ADDRESS <b>69X-3</b>			
3. NAME OF DECEASED (Type or print) <b>JOSEPH SCHREIBER</b>				4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 13, 1883</b>	
9. AGE (In years last birthday) <b>76</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steamfitter- retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Long Island R.R.</b>			
13. FATHER'S NAME <b>Charles Schreiber</b>				14. MOTHER'S MAIDEN NAME <b>Abigail Spline</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Family records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>720J</b> DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Chronic &amp; decompensation</b> DUE TO <b>with Chronic Bronchitis</b> (c) <b>with Chronic Bronchitis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19</b> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Richmond Hills, Long Island, N.Y.</b>				20g. (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 14, 1960</b> to <b>April 19, 1960</b> that (I) (we) last saw the deceased alive on <b>April 19, 1960</b> and that death occurred at <b>11 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Charles F. Donnell</b>				22b. DATE SIGNED <b>4/19/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Charles F. Donnell</b>				22d. ADDRESS <b>756 1/2 York Rd</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Removal/Burial</b>		23b. DATE THEREOF <b>April 23, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Richmond Hills, Long Island, N.Y.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>APR 22 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneale</b>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4340

CERTIFICATE OF DEATH

Reg. Dist. No.

04281

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>323 Southwind Road</b>		d. STREET ADDRESS <b>323 Southwind Road</b>	
3. NAME OF DECEASED (Type or print) <b>Agnes B. Seohnlein</b>		4. DATE OF DEATH <b>April 23, 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 21, 1902</b>
9. AGE (In years last birthday) <b>58</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>David L. Broadfoot</b>		14. MOTHER'S MAIDEN NAME <b>Berdie L. King</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>213-12-0404</b>	
17. INFORMANT <b>Robert L. Seohnlein, Reisterstown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Coronary Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Hypertensive Cardiac Renal Vasculitis 10 yrs.</b> DUE TO <b>Hypertensive Cardiac Renal Vasculitis 10 yrs.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>3 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 4, 1950</b> to <b>April 23, 1960</b> , that I last saw the deceased alive on <b>April 16, 1960</b> , and that death occurred at <b>MD</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles F. O'Donnell M.D.</b>		ADDRESS (Street, city or town, state) <b>7501 7th Rd</b>	
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell</b>		DATE SIGNED <b>4/25/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 26/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>APR 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Kneiss</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 9, 13 & 14 Film G-61 4/28/60

04283

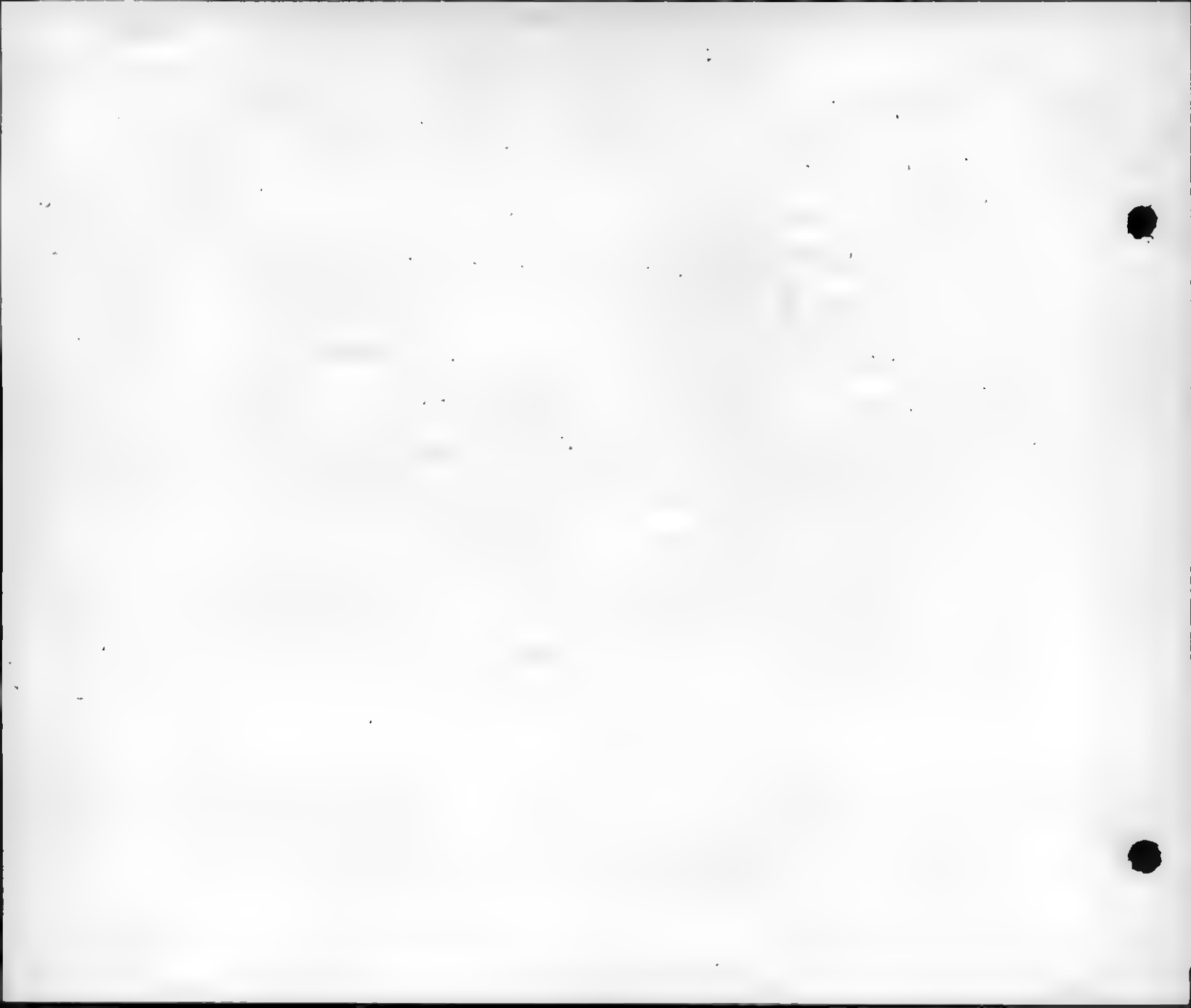
4341

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>L</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Likesville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7514 Glade Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BENJAMIN B. SHANNON</u>				4. DATE OF DEATH <u>4-22-1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-15-1902</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Julius unknown</u>				14. MOTHER'S MAIDEN NAME <u>Bessie unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Ethel Shannon - Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Cardiac debility</u> DUE TO <u>Coronary infarction (myocardial)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic</u> (c) <u>10 yrs</u> DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10/1</u> , 19 <u>40</u> , to <u>4/22</u> , 19 <u>60</u> that I last saw the deceased alive on <u>4/21</u> , 19 <u>60</u> , and that death occurred at <u>7:29</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. C. Feldman</u> M.D.				ADDRESS (Street, city or town, state) <u>1440 E. Baltimore</u> DATE SIGNED <u>4/23/60</u>			
PHYSICIAN'S NAME (Type) <u>S. C. Feldman</u>				<u>Baltimore Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-24-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 E. Baltimore Pl</u>				24a. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

64284

4342

1 PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1507 Norman Ave.</b>				d. STREET ADDRESS <b>1507 Norman Ave.</b>			
3. NAME OF <del>DECEASED</del> (Type or print) First <b>BERNARD</b> Middle <b>T.</b> Last <b>SHETTLE</b>				4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>1960</b>			
5 SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1908</b>		9. AGE (In years last birthday) <b>51</b> yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
			11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Shettle</b>				14. MOTHER'S MAIDEN NAME <b>Ella R. (unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-07-3601</b>		17. INFORMANT Address <b>Mrs. Miriam M. Shettle-1507 Norman Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LEFT LUNG</b> <b>163</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour <b>o m.</b> <b>19</b> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>April 4, 1960</b> to <b>April 11, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 10, 1960</b> , and that death occurred at <b>2:15 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>William A. Pickett</i>				22b. DATE SIGNED <b>4 12 60</b>		22c. PHYSICIAN'S NAME (Type) <b>William A. Pickett</b>	
22d. ADDRESS <b>11000 W. ...</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-14-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Tichenor &amp; Son - Balt. 17</i>				25a. REC'D BY REGISTRAR <b>APR 14 60</b>		25b. REGISTRAR'S SIGNATURE <i>Wm. J. Tichenor</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1/23 X



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4233 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>REISTERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>X REISTERSTOWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CHURCH ROAD</b>		d. STREET ADDRESS <b>CHURCH ROAD</b>	
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b> <b>ELI KELLY SHOCK</b>		4. DATE OF DEATH Month Day Year <b>APRIL 10 1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 4, 1886</b>
9. AGE (In years last birthday) <b>74</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINE OPRT.-RET</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BLACK &amp; DECKER</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>GEORGE SHOCK</b>		14. MOTHER'S MAIDEN NAME <b>EMMA PARKS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-10-9929</b>	
17. INFORMANT <b>FAMILY RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis - acute</b> 4-3-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis - generalized</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1957</b> to <b>April 10, 1960</b> , that I last saw the deceased alive on <b>April 10, 1960</b> , and that death occurred at <b>7:45 PM</b> , from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Clarence E. McWilliams</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Reisterstown, Maryland April 10, 1960</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4-13-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>SATERS CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>LUTHERVILLE MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Son's</b>		ADDRESS <b>Lewisson, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Clarence E. McWilliams</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 *A*  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4343 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64201

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Glen Arms</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Glen Arms</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glen Arms Rd.</u>		d. STREET ADDRESS <u>Glen Arms Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>BERNICE FARRIS SIMON</u>		4. DATE OF DEATH <u>April 15 19 60</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/1/12</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Arkansas</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John L. Jordan</u>		14. MOTHER'S MAIDEN NAME <u>Verna Barnes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mr. Willy Kurt Simon</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> +34.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cor pulmonale</u> DUE TO (c) <u>Scoliosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>  </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles S. Petty</u>		DATE SIGNED <u>4/15/60</u>	
EXAMINER'S NAME (Type) <u>Charles S. Petty</u>		M.D. <u>  </u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/18/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR <u>Leonard Y. Ruck 5305 Harford Road #14</u>		24a. REC'D BY REG. STRAR <u>APR 18 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

MEDICAL CERTIFICATION

1/24/1

4228

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>BALTIMORE</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>BALTO</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>AR BUT US</i>		c. LENGTH OF STAY IN 1b <i>4 YRS</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>57 Cerbutus</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1347 Poplar Ave</i>		d. STREET ADDRESS <i>1347 Poplar Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Martha E Smith</i>		4. DATE OF DEATH <i>April 2 1960</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6 August 1877</i>
9. AGE (In years last birthday) <i>82 yrs.</i>		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>PENNA</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>CHARLES MADDEN</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>NO</i>		16. SOCIAL SECURITY NO <i>NONE</i>	
17. INFORMANT <i>Richard H. Duvall</i>		Address <i>1347 Poplar Ave</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> DUE TO <i>Stroke</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive cardiovascular disease</i> DUE TO (c) <i>several days</i>		INTERVAL BETWEEN ONSET AND DEATH <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 21 1960</i> to <i>April 2 1960</i> , that I last saw the deceased alive on <i>April 2 1960</i> , and that death occurred at <i>7:30 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry Armanas M.D.</i>		DATE SIGNED <i>April 4 1960</i>	
PHYSICIAN'S NAME (Type) <i>HENRY ARMANAS M.D.</i>		<i>1934 Wilkens Ave Balto 23, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>April 5-1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Finksburg Cem</i>		22d. LOCATION (City, town, or county) (State) <i>CARROLL Co MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter Pratt</i>		ADDRESS <i>Pratt &amp; Spricker</i>	
24a. REC'D BY REGISTRAR <i>APR 5 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





420.0



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64289

4345

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <u>Baltimore</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) <b>a. STATE</b> <u>Maryland <b>b. COUNTY</b> <u>Baltimore</u> </u>			
<b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>		<b>c. LENGTH OF STAY IN TB</b> <u>2 1/2 wks</u>		<b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <u>3637 York Rd. Baltimore Md.</u>			
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <u>2039 York Road</u>				<b>d. STREET ADDRESS</b> <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Stanley</u> <u>Harold</u> <u>Smith</u>				<b>4. DATE OF DEATH</b> <u>April</u> <u>22</u> <u>1960</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>August 1932</u>			
<b>9. AGE</b> (In years last birthday) <u>27 yrs.</u>		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Auto mechanic</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>Saul H. Smith</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Jessie R. Wendell</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, no, or unknown) <u>Yes</u> <u>Navy - no war</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>?</u>		<b>17. INFORMANT</b> <u>Brother. Joseph F. Smith, Timonium Md.</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Gunshot wound, center (anterior) chest</u> <b>DUE TO</b> <b>(b)</b> <u>Suicide with 22 rifle</u> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> <b>DUE TO</b> <b>(c)</b> <u>  </u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/></b>					
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
<b>20f. (City or town)</b> <u>  </u>		<b>(County)</b> <u>  </u>		<b>(State)</b> <u>  </u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input checked="" type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <u>Robert C. Hurlman</u>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>April 22, 1960</u>			
<b>EXAMINER'S NAME (Type)</b> <u>  </u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>4-25-60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>INDIAN MT. CEMETERY</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>ROMNEY</u>		<b>(State)</b> <u>WEST VIRGINIA</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John Bruno Sons</u>			<b>ADDRESS</b> <u>Sawson, Md.</u>				
<b>24a. REC'D BY REGISTRAR</b> <u>  </u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hume</u>		<b>DATE</b> <u>APR 28 '60</u>			

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any other certificate is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

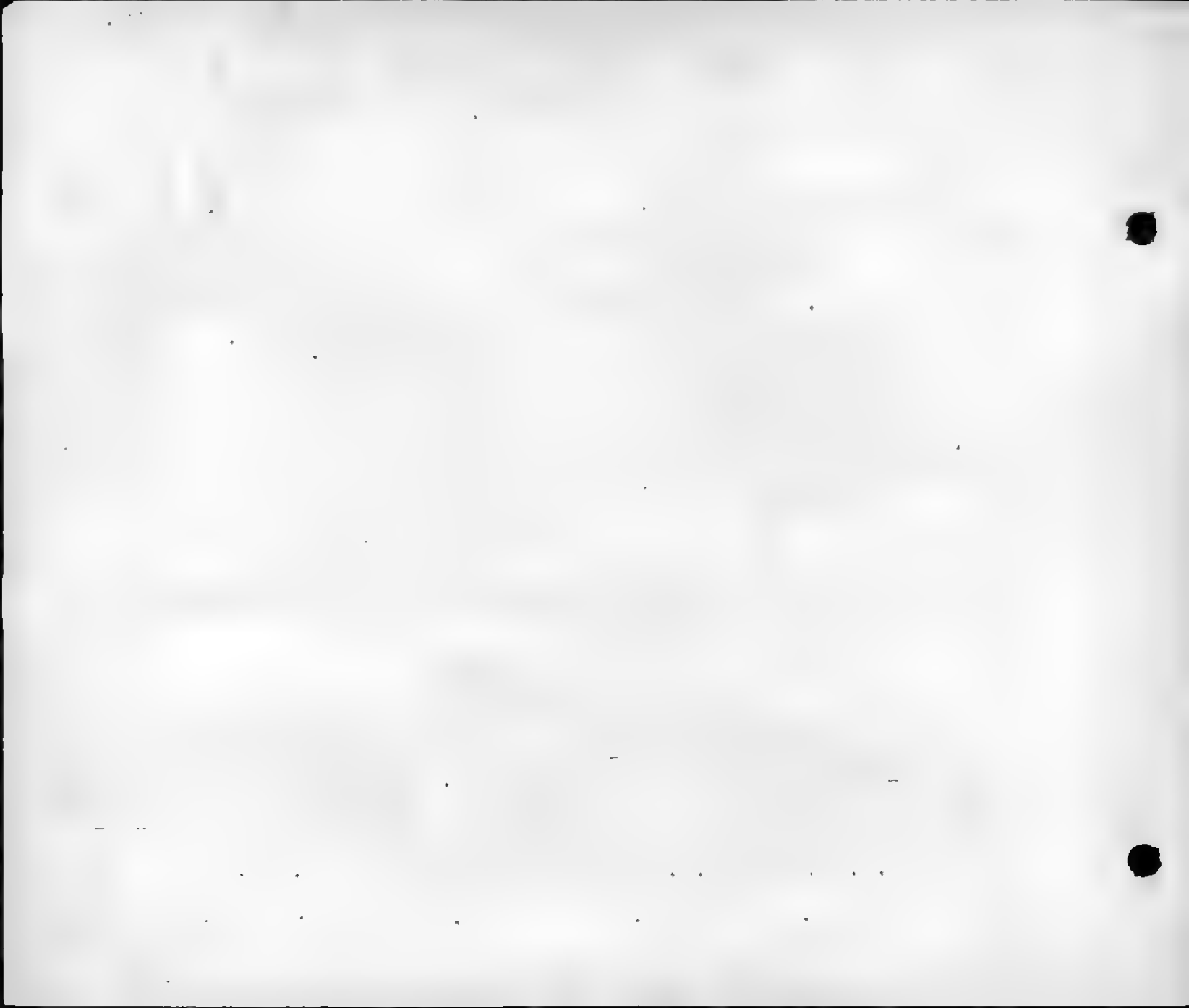
64290

4229

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethrop</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethrop</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4313 Washington Blvd.</u>			d. STREET ADDRESS <u>4313 Washington Blvd.</u>		
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>SMITH</u> Last			4. DATE OF DEATH Month <u>APRIL</u> Day <u>21</u> Year <u>19 60</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 10, 1880</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Va. Lunberg Ct. House</u>	
13. FATHER'S NAME <u>Thomas Smith</u>			14. MOTHER'S MAIDEN NAME <u>Betsy ?</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>N.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Benjamin Smith 4313 Washington Blvd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arterio-sclerosis</u> DUE TO (c) <u>?</u>					INTERVAL BETWEEN ONSET AND DEATH <u>7</u> days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-14-60</u> , 19 <u>60</u> , to <u>4-21-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-21-60</u> , 19 <u>60</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>C. F. Maloney, M.D.</u>			ADDRESS (Street, city or town, state) <u>57 Winters Lane Catonsville, 28. Md.</u>		
PHYSICIAN'S NAME (Type) <u>C. F. Maloney, M.D.</u>			DATE SIGNED <u>4-21-60</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 25, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>	
22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Katie R. Williams</u>		24a. REC'D BY REGISTRAR <u>APR 26 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knecht</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

4346

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

# CERTIFICATE OF DEATH

64291

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Armstrong Home</u>				d. STREET ADDRESS <u>1663 Redwood Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>D.</u> Last <u>Snowman</u>				4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 7, 1904</u>		9. AGE (In years last birthday) <u>56</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Lewis Railing</u>				14. MOTHER'S MAIDEN NAME <u>Ida Trundle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-10-100000</u>		17. INFORMANT <u>Lewis D. Snowman</u>		Address <u>1663 Redwood Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Lung</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Ovary</u> DUE TO (c) <u>6 months</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 2, 1960</u> to <u>April 7, 1960</u> , that (I) <u>last</u> saw the deceased alive on <u>April 7, 1960</u> , and that death occurred at <u>10:00</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>L. H. Jenkins &amp; Sons Co.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>4/11/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>L. H. Jenkins &amp; Sons Co.</u>				22d. ADDRESS <u>1501 York Rd. Baltimore</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-13-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Memorial</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins &amp; Sons Co.</u> ADDRESS <u>1501 York Rd.</u>				25a. REC'D BY REGISTRAR <u>APR 12 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Henth</u>	

3  
775.0

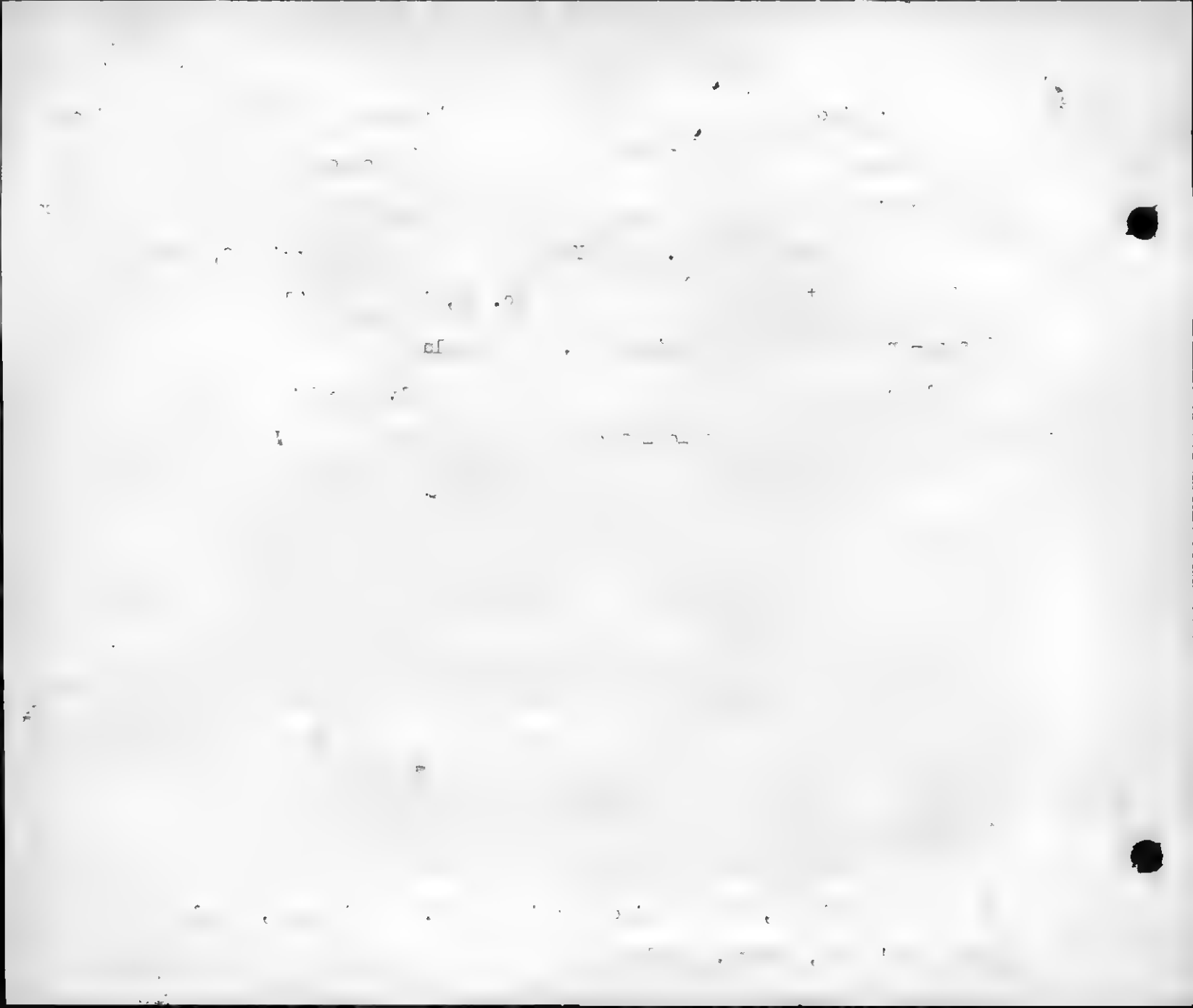
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4347 CERTIFICATE OF DEATH

64292-

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>1 week</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Codd Nursing Home</b>		e. STREET ADDRESS <b>7906 Knellwood Road</b>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>H.</b> Last <b>SNIDER</b>		4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 11, 1888</b>
9. AGE (In years last birthday) yrs <b>71</b>		10. IF UNDER 1 YEAR: Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman- retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing Mfr.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Elmer Snyder</b>		14. MOTHER'S MAIDEN NAME <b>Emily Medcalf</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO <b>216-05-6264</b>	
17. INFORMANT <b>Family Records</b>		Address <b>1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b> DUE TO <b>Cardiac Decompensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Hypertensive Hypertensive</b> DUE TO <b>Hypertensive Hypertensive</b> (c) <b>Hypertensive Hypertensive</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 Hrs</b> <b>5 days</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o</b> m <b>19</b> p m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>Feb 5, 1947</b> to <b>April 23, 1960</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>April 23, 1960</b> and that death occurred at <b>2 P M</b> , from the causes and on the date stated above			
22a. SIGNATURE <b>Charles F O'Donnell</b> M.D.		22b. DATE SIGNED <b>APR 23 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles F O'Donnell</b>		22d. ADDRESS <b>7501 York Rd - Towson Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 27, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d. LOCAT ON (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 28 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4348  
CERTIFICATE OF DEATH

64253

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>15</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>206 W. Pennsylvania Avenue</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
f. STREET ADDRESS <b>208 W. Pennsylvania Avenue</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BERNARD</b> Middle <b>CHARLES</b> Last <b>SOOTHCAFE</b>		4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 12, 1912</b>
9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Vermont</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Leslie Soothcafe</b>		14. MOTHER'S MAIDEN NAME <b>Agatha Hillard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>071-12-5221</b>	
17. INFORMANT <b>Personal Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY ARTERY OCCLUSION</b> 42C.1) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 HRS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1957</b> to <b>APR 19</b> 1960, that (I) ( <del>me</del> ) last saw the deceased alive on <b>APR 19</b> 1960, and that death occurred at <b>2:30</b> PM, from the causes and on the date stated above.			
22a. SIGNATURE <b>T. C. Siwinski</b>		22b. DATE SIGNED <b>APR 20, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>T. C. SIWINSKI</b>		22d. ADDRESS <b>206 W. PENNA AV TOWSON 4 Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Removal/Burial</b>		23b. DATE THEREOF <b>April 23, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Fort Edward, N.Y.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>APR 22 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>C. E. H. H. H.</b>			

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# 1 4 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4220 CERTIFICATE OF DEATH

Reg. Dist. No.

04294

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>7 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Res. 1823 Dunmere Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Edward</b> Last <b>Spicer</b>		4. DATE OF DEATH Month <b>April</b> Day <b>10</b> , Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 7, 1875</b>
9. AGE (In years last birthday) <b>84</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	11. IF UNDER 24 HRS Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Adolphus Spicer</b>		14. MOTHER'S MAIDEN NAME <b>Mary Young</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-09-9957</b>	
17. INFORMANT <b>Mrs. Laura Coleman</b>		Address <b>1823 Dunmere Rd. 22</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>H-S-C-V DISEASE</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Security</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BLINDNESS - CAUSE UNDETERMINED</b>			INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb. 1960</b> to <b>April 10, 1960</b> , that I last saw the deceased alive on <b>April 1, 1960</b> , and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>M. B. Davis</b>		DATE SIGNED <b>4/11/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-13-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>		22d. LOCATION (City, town, or county) (State) <b>German Hill Rd. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda</b>		ADDRESS <b>7922 Wise Ave. 22. Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Richard S. Kneel</b>	

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

451.c

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

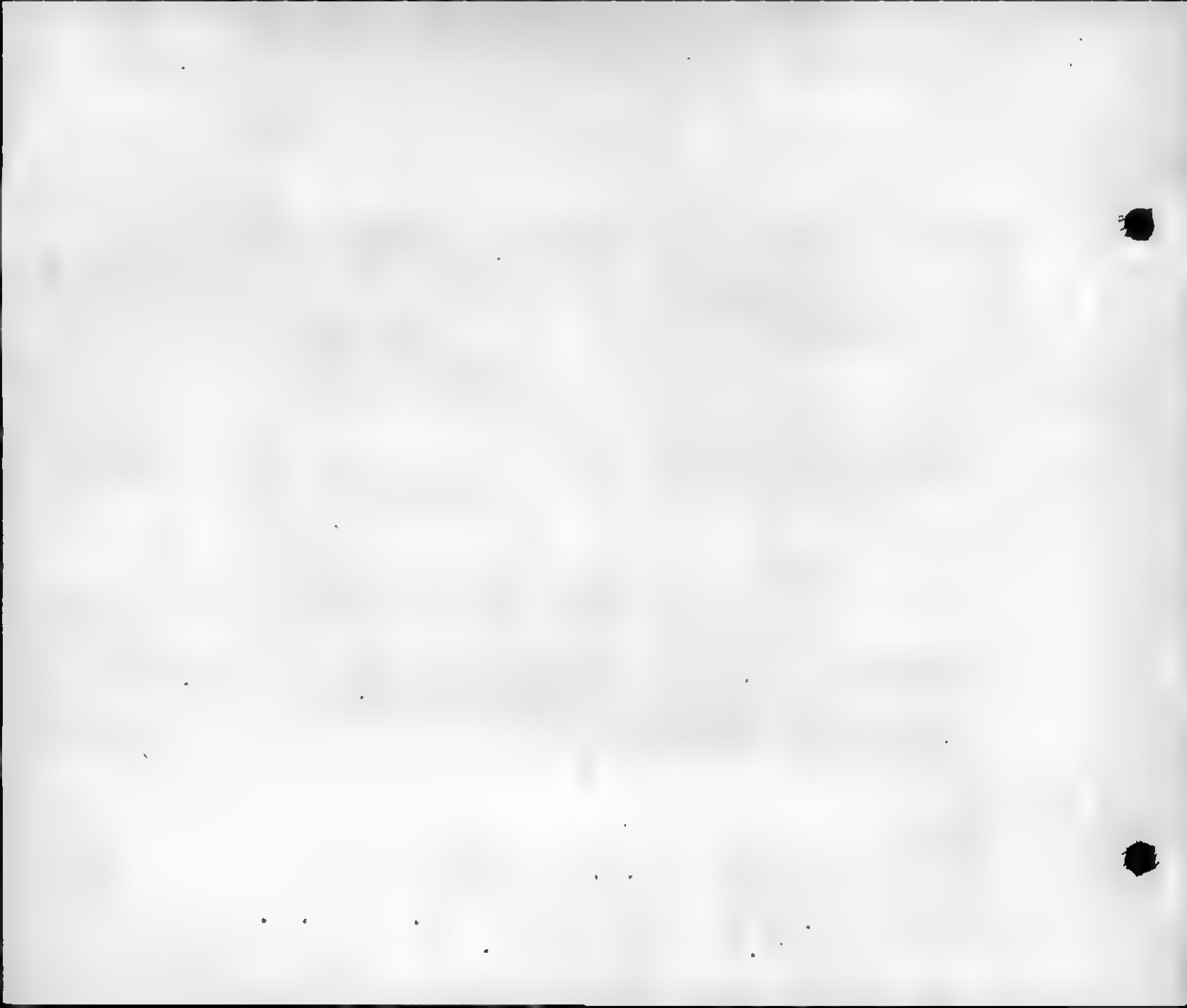
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>27yr5mth26dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Pejatez (Peter)</b> Middle <b>(Stauraplos)</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1877</b>
9. AGE (in years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Greece</b>		12. CITIZEN OF WHAT COUNTRY? <b>Greece</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Foreign body in food</b> (c) <b>in throat during eating meal</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>occurred during a meal</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>While eating lunch pt. became markedly cyanotic, without respirations. Large piece of meat was removed from the throat.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>12:30 4-19 19 60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) (County) (State) <b>Catonsville 28, Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>George M. Kieffer</b>		DATE SIGNED <b>4-19-60</b>	
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 22/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cmty.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir. 4101 Edmondson Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 22 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knease</b>			

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55



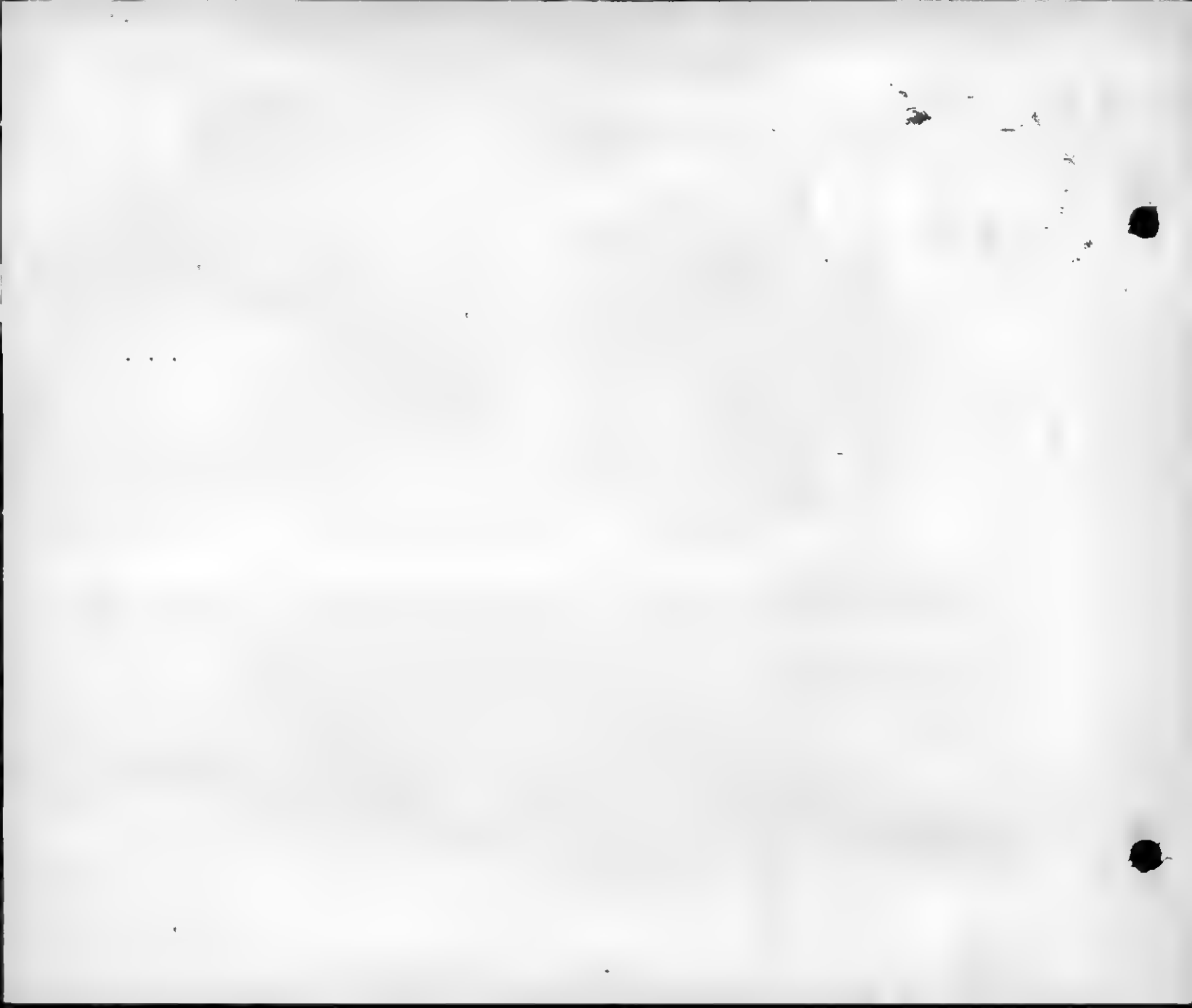
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4350 CERTIFICATE OF DEATH

Reg. Dist. No. 296

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River (20)</u>		c. LENGTH OF STAY IN 1b <u>54</u> <u>Essex (21)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ivy Hall Convalescent Home</u>		d. STREET ADDRESS <u>1802 Elk Road</u>	
3. NAME OF DECEASED (Type or print) <u>MATTI DA STEINGRUBNER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 3, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Langgardner</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-03-9344B</u>	
17. INFORMANT <u>Rudolph Steingrubner</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular accident</u> DUE TO <u>Arteriosclerosis disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1</u> 19 <u>60</u> to <u>April 24</u> 19 <u>60</u> , that I last saw the deceased alive on <u>April 24</u> 19 <u>60</u> , and that death occurred at <u>5 A</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Baltimore</u> DATE SIGNED <u>4/25/60</u>			
ACTUAL SIGNATURE <u>George Langgardner</u>		PHYSICIAN'S NAME (Type) <u>James Rudzinski</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/27/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore County, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Rudzinski</u>		24a. REC'D BY REGISTRAR <u>APR 27 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		24c. ADDRESS <u>1407 Eastern Ave.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re-executed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64297

## CERTIFICATE OF DEATH

Reg. Dist. No.

4351

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1yr9mth4dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena, Maryland</b>	
		d. STREET ADDRESS <b>Main and Meadow Roads</b>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Herman</b> Last <b>Stindt</b>		4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 23, 1876</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min.	IF UNDER 24 HRS Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>iron foundry</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Stindt</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown; If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO <b>212-03-2486</b>	
INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 16, 1960</b> to <b>April 21, 1960</b> , that I last saw the deceased alive on <b>April 21, 1960</b> , and that death occurred at <b>11:10 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Isadore Tuerk</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL 4-21-60</b>	
PHYSICIAN'S NAME (Type) <b>Isadore Tuerk, M. D.</b>		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>4-23-60</b>		22b. DATE THEREOF <b>4-23-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ed. Casey - 130 E. Foul St.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 22 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

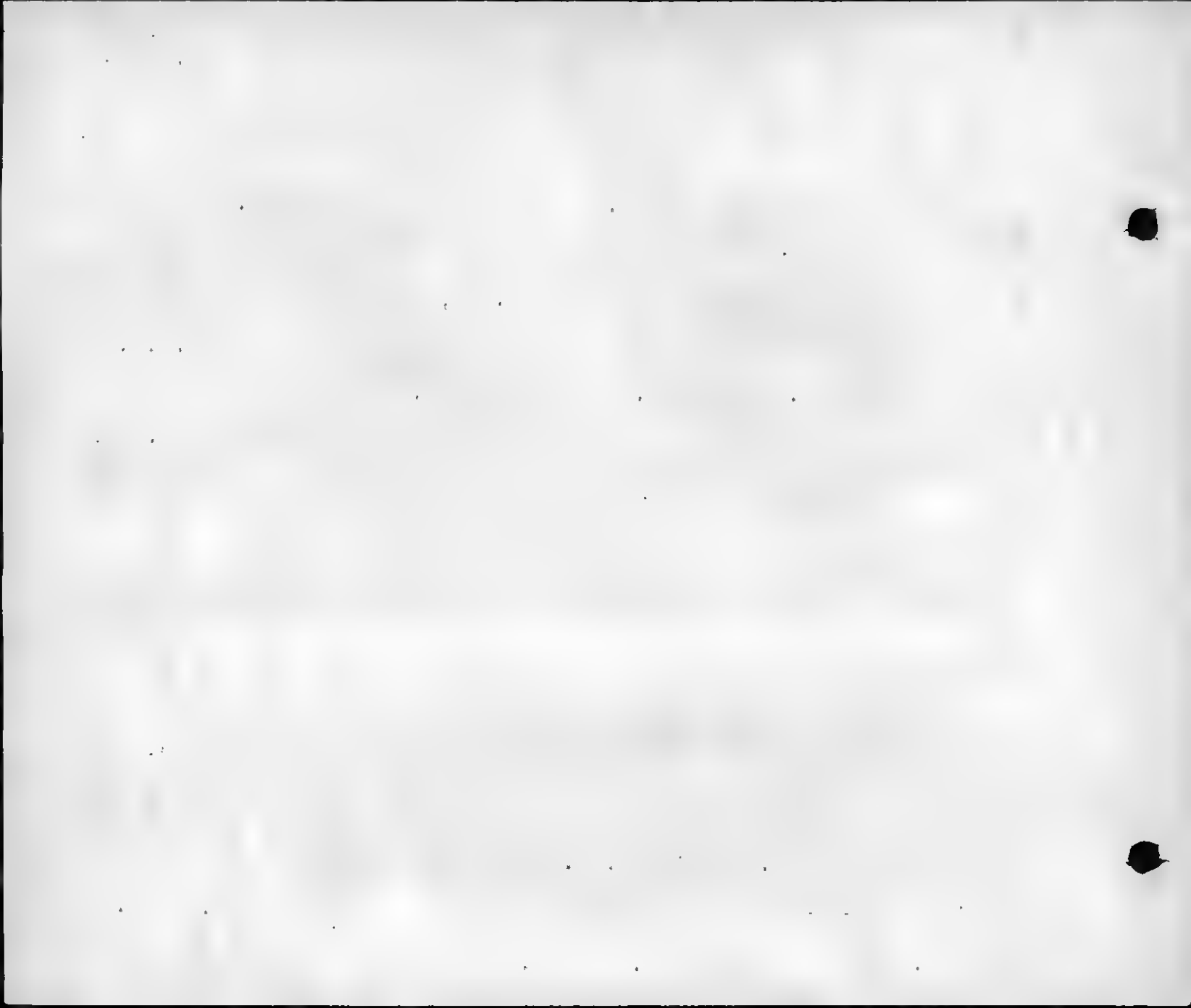
Reg. Dist. No.

Item 20 Film 262 5-0-

4221

64258

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN 1b <b>??</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8600 Block Sandy Plains Rd.</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> d. STREET ADDRESS <b>1926 Quentin Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Edward</b> Last <b>Stokes</b>			4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>19 60</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 22, 1946</b>	9. AGE (In years last birthday) <b>13</b> yrs.	IF UNDER 1 YEAR Months <b>13</b> Days <b>13</b> Hours <b>13</b> Min. <b>13</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Inverness</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
13. FATHER'S NAME <b>John A. Stokes Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Erma J. Howard</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>William Moore</b> Address <b>1926 Quentin Rd. 22, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning, Accidental</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>1-18</b> (a), stating the underlying cause last, (c) <b>1-18</b> DUE TO					INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1-18</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Patient dove from boat and evidently seized by cramps</b>			
20c. TIME OF INJURY Month, Day, Year <b>4-23- 19 60</b> Hour, <b>1:55</b> <b>a.m.</b> <b>p.m.</b>	20d. INJURY OCCURRED. While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Beach</b>	20f. (City or town) <b>6612 Sandy Plain Rd Balto</b> (County) <b>Md.</b> (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Jack C. Collins</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4-23-60</b>	
EXAMINER'S NAME (Type) <b>Jack C. Collins M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-27-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		22d. LOCATION (City, town, or county) <b>Eastern Blvd. Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda</b> ADDRESS <b>7922 Wise Ave. 22, Md.</b>			24a. REC'D BY REGISTRAR <b>DATE pp 2 6 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kane</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64299

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTO.</u> <span style="float: right;">4352</span> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>ESSEX</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>871 BACK RIVER NECK RD</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u> d. STREET ADDRESS <u>871 BACK RIVER NECK RD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>IYA V STREIB</u> 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>MAY 25, 1907</u> 9. AGE (In years last birthday) <u>52</u> yrs.		<b>4. DATE OF DEATH</b> Month <u>APRIL</u> Day <u>14</u> Year <u>1960</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) <u>PA.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>EMER HECKMAN</u> 14. MOTHER'S MAIDEN NAME <u>KESLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>EDW. L. STREIB</u> Address <u>(SAME AS ABOVE)</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-V-DISEASE</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year _____ Hour _____ o. m. _____ p. m. _____ 19 _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
<b>ACTUAL</b> <u>M. B. Davis</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>4-18-60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u> 22d. LOCATION (City, town, or county) <u>BALTO.</u> (State) <u>MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Connelly</u> ADDRESS <u>418 Eastern Blvd.</u> 24a. REC'D BY REGISTRAR <u>APR 19 '60</u> 24b. REGISTRAR'S SIGNATURE <u>John B. Connelly</u>		25. DATE <u>4/18/60</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4353

CERTIFICATE OF DEATH

64300

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>8 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
f. STREET ADDRESS <b>1522 N MONROE STREET</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>M</b> Last <b>TARTAR</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>9</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>COLORED</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 21, 1911</b>	
9. AGE (In years last birthday) <b>48</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CUSTODIAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>DEPT OF EDUCATION</b>			
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>GEORGE M TARTAR</b>				14. MOTHER'S MAIDEN NAME <b>LYDIA COATES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW-11 215-03-1353</b>			
17. INFORMANT <b>CLIN REC VAH BALTIMORE MD FT HOWARD DIVISION</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA</b> <b>441X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>LYMPHOSARCOMA</b> (c) <b>GENERALIZED LYMPHADENOPATHY</b> <b>CACHEXIA</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b> <b>2 YEARS</b> <b>UNKNOWN</b> <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY EDEMA</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that <b>M</b> (this hospital) attended the deceased from <b>April 1, 1960</b> to <b>April 9, 1960</b> , that <b>M</b> (we) last saw the deceased alive on <b>April 9, 1960</b> , and that death occurred at <b>1:45 pm</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Arthur T. Faulk, M.D.</b>				22b. DATE SIGNED <b>9-10-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR T. FAULK, M.D.</b>				22d. ADDRESS <b>VAH, Balto., Md. Ft. Howard Division</b>			
23a. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-13-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S Phillips</b>				25a. REC'D BY REGISTRAR <b>DATE APR 12 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>1808-10 N Monroe St</b>				25c. REGISTRAR'S SIGNATURE <b>Baltimore 17 Md</b>			

491X



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

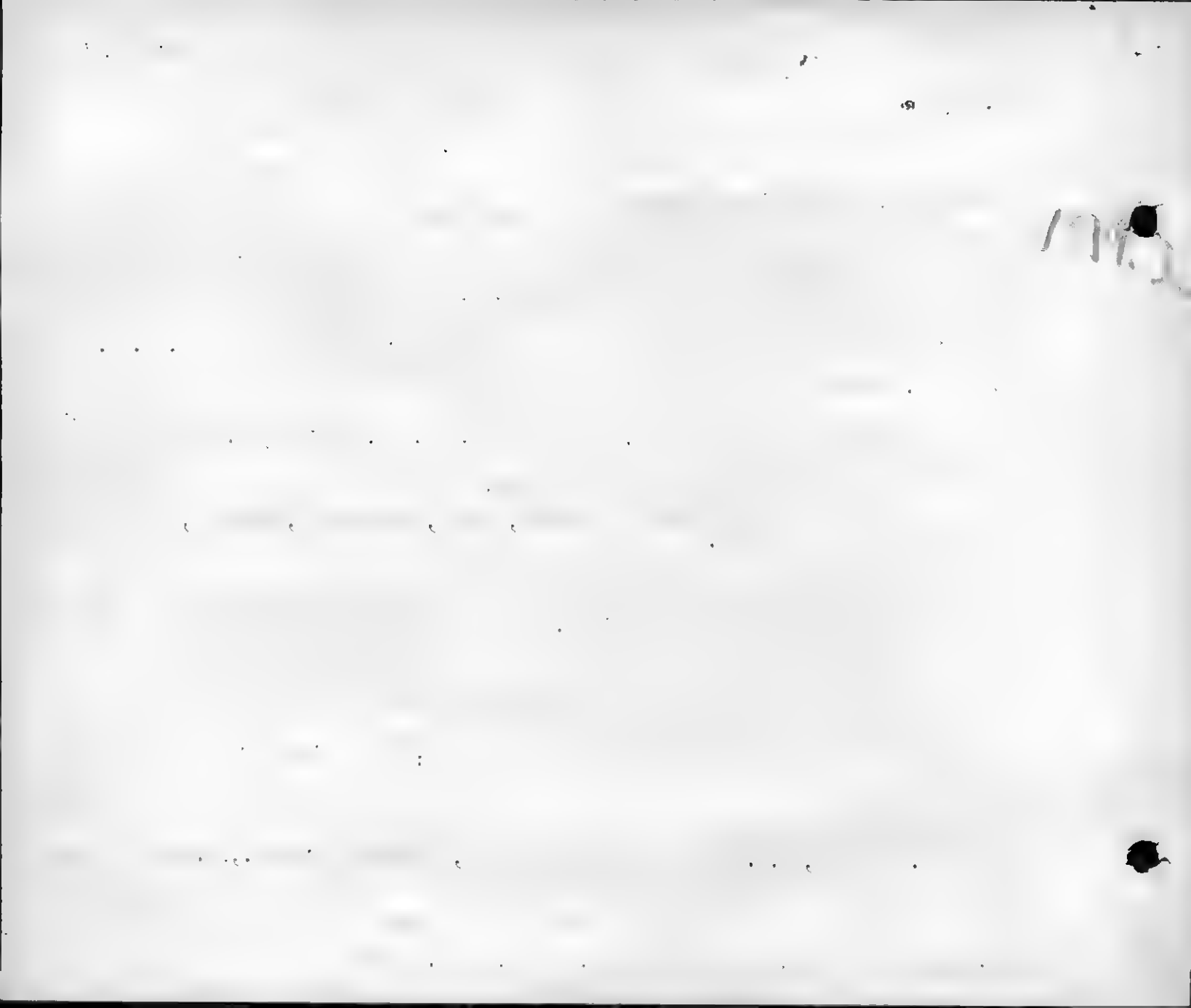
4354

CERTIFICATE OF DEATH

04301

1 PLACE OF DEATH BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived IF institution: Residence before admission) a. STATE MARYLAND b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write nearest corporate town) FORT HOWARD		c. LENGTH OF STAY IN 1b 31 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA			
d. NAME OF HOSPITAL (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS --		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HOWARD HAMPTON TAWNEY				4. DATE OF DEATH Month Day Year April 17 1960			
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 22, 1895		9. AGE (In years last birthday) 64 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Winchester, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James T. Tawney				14. MOTHER'S MAIDEN NAME Margaret Isadore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 705-10-4873		17. INFORMANT Baltimore 18, Maryland Clin, Rec. Vet. Adm. Hospital, Ft. Howard, Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 DUE TO BRONCHOGENIC CARCINOMA DUE TO METASTATIC CARCINOMA, LUNGS, LYMPH NODES, ADRENALS, RIBS. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. DUE TO (c) UNKNOWN PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c). ARTERIOSCLEROTIC HEART DISEASE.							INTERVAL BETWEEN ONSET AND DEATH OLD UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from March 17, 1960, to April 17, 1960, that (1) (we) last saw the deceased alive on April 17, 1960, and that death occurred at P. M. from the causes and on the date stated above.							
22a. SIGNATURE JOHN D. TALBERT, M.D.				22b. DATE 4/18/60			
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-20-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Hartford Rd., Balto. 14, Md.				25a. REC'D BY REGISTRAR APR 21 '60		25b. REGISTRAR'S SIGNATURE W. L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4355 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

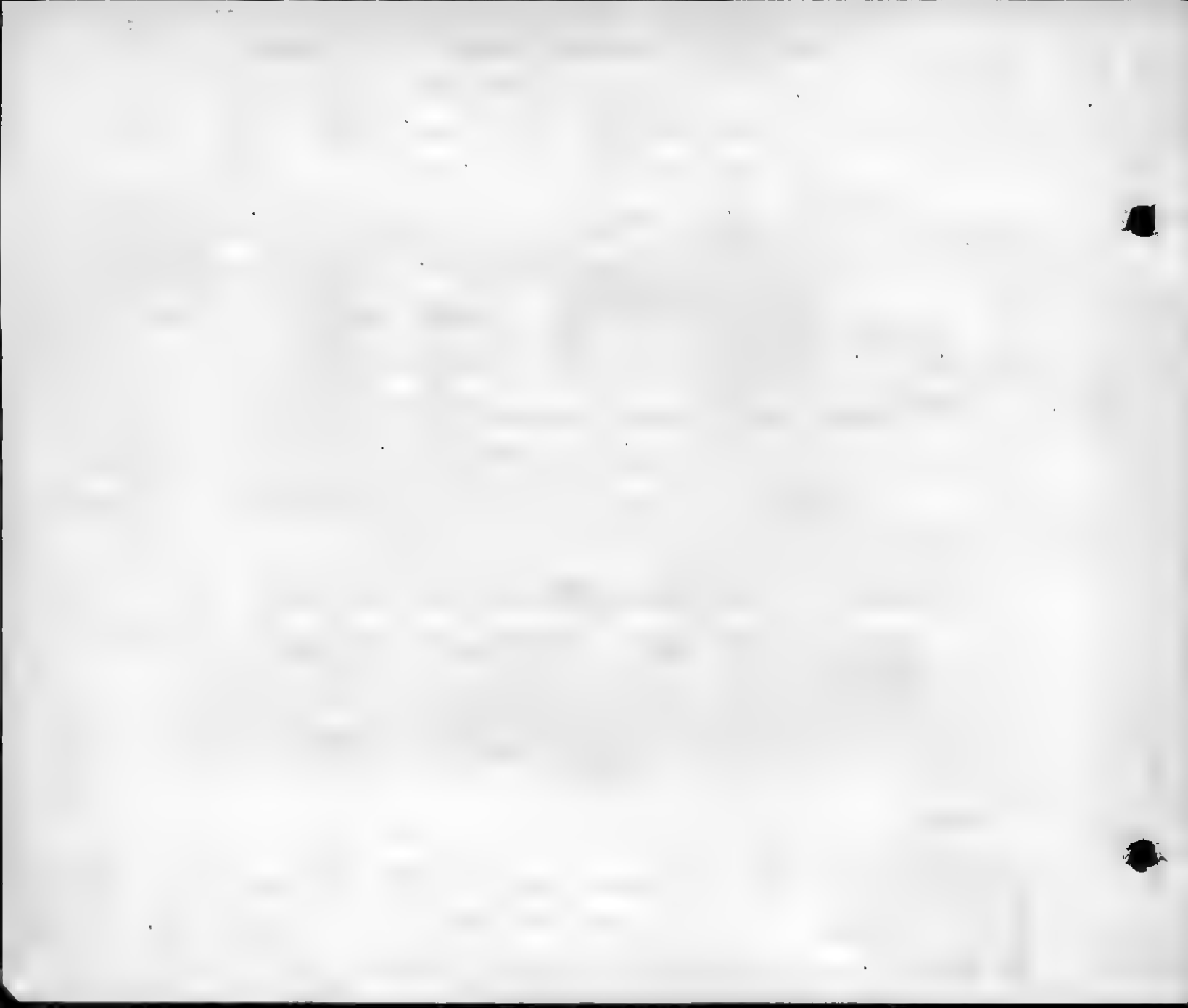
64302

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2908 Oakcrest Ave.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Parkville</u> d. STREET ADDRESS <u>2908 Oakcrest Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Edward</u> Middle <u>Lewis</u> Last <u>Taylor Sr.</u>				<b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>18</u> Year <u>19 60</u>													
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>July 30-87</u>		<b>9. AGE</b> (In years last birthday) <u>72</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Ret. Stat. Engineer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Maryland</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>									
<b>13. FATHER'S NAME</b> <u>Major Taylor</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Jones</u>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service) <u>212-05-8911</u>		<b>17. INFORMANT</b> <u>Elizabeth M. Taylor</u>		Address <u>same</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>Myocardial Thrombosis</u>  <u>120.1</u> DUE TO  <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> </td> <td colspan="2"> <b>(b)</b> <u>Coronary Artery Disease</u>  <b>DUE TO</b> </td> <td colspan="2" rowspan="2"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>3 hr.</u>  <u>yes +</u>  <u>under</u> </td> </tr> <tr> <td colspan="2"></td> <td colspan="2"> <b>(c)</b> <u>Diathermy induced Cardiovascular</u>  <b>DUE TO</b> </td> </tr> </table>								<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Myocardial Thrombosis</u> <u>120.1</u> DUE TO <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>		<b>(b)</b> <u>Coronary Artery Disease</u> <b>DUE TO</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 hr.</u> <u>yes +</u> <u>under</u>				<b>(c)</b> <u>Diathermy induced Cardiovascular</u> <b>DUE TO</b>	
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Myocardial Thrombosis</u> <u>120.1</u> DUE TO <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>		<b>(b)</b> <u>Coronary Artery Disease</u> <b>DUE TO</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 hr.</u> <u>yes +</u> <u>under</u>													
		<b>(c)</b> <u>Diathermy induced Cardiovascular</u> <b>DUE TO</b>															
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>																	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
<b>ACTUAL SIGNATURE</b> <u>John C. Hyle</u> <b>NAME (Type)</b> <u>JOHN C. Hyle</u>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>													
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u>		<b>22b. DATE THEREOF</b> <u>4/21/60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Parkwood Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Baltimore, Md.</u>											
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Leonard G. Ruck 5305 Harford Rd</u>				<b>24a. REC'D BY REGISTRAR</b> DATE <u>APR 21 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>William L. French</u>											

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 1 hour after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4230

## CERTIFICATE OF DEATH

64303

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9810 HARFORD RD</u>		e. STREET ADDRESS <u>19810 HARFORD RD</u>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>V</u> Last <u>THOMPSON</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-5-1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secy.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Water Supply Co</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Anthony G. Millard</u>		14. MOTHER'S MAIDEN NAME <u>Adelaide E. Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>208-05-3807</u>	
17. INFORMANT <u>PAUL L. Thompson</u>		Address <u>9810 HARFORD RD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Premia &amp; renal ischemia</u> (c) <u>Generalized Arteriosclerosis</u> <u>Coronary artery Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>15 yr.</u> <u>2 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Failure Chronic</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1955</u> to <u>April 1960</u> , that I last saw the deceased alive on <u>April 13, 1960</u> , and that death occurred at <u>5:23 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>BALTO</u> DATE SIGNED <u>4/13/60</u>			
ACTUAL SIGNATURE <u>Frank T. Kasik</u>		M.D. <u>BALTO</u>	
PHYSICIAN'S NAME (Type) <u>DR FRANK T. KASIK</u>		<u>9005 HARFORD RD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/18/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Waterford Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Waterford PA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS F. EVANS &amp; SON</u>		ADDRESS <u>8802 HARFORD RD</u>	
24a. REC'D BY REGISTRAR <u>APR 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

420.1

4356

CERTIFICATE OF DEATH

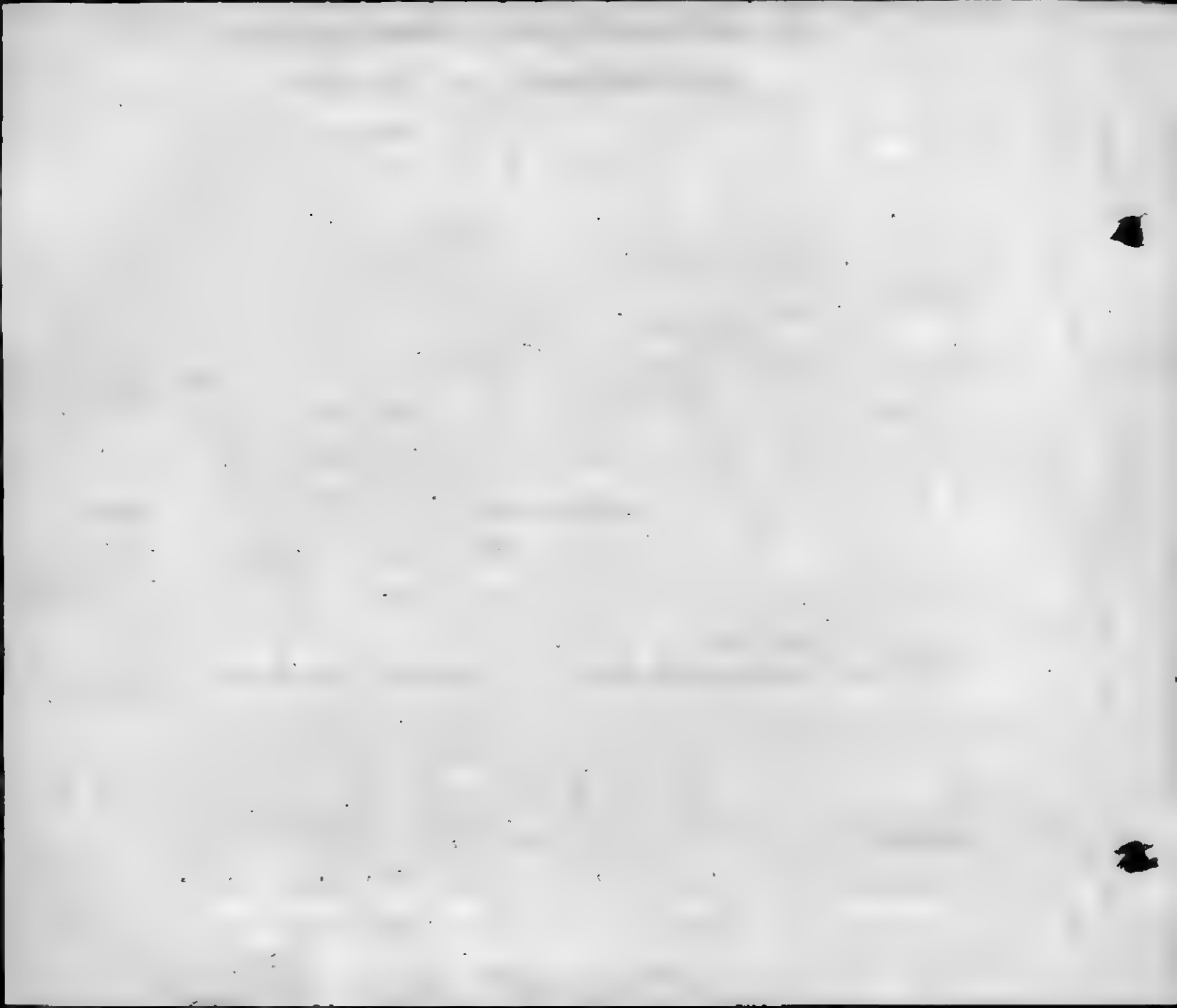
Reg. Dist. No. 32

1. PLACE OF DEATH COUNTY <u>Baltimore County</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Wilson</u> LENGTH OF STAY (in this place) <u>6 days</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto. City</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> 14 3017 STREET ADDRESS (If rural give location) <u>3210 Tyndale Ave</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>George David Thorn</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4 18 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5/3/1888</u>
9. AGE last birthday <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Thorn</u>		14. MOTHER'S MAIDEN NAME <u>Saranda Sterner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH X IMMEDIATE CAUSE (A) <u>Pulmonary Emphysema</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary Tuberculosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral Vascular Accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 Years</u> <u>29 years</u> <u>24 hrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4/12</u> , 19 <u>60</u> , to <u>4/18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/18</u> , 19 <u>60</u> , and that death occurred at <u>7:45</u> AM, from the causes and on the date stated above. SIGNATURE <u>Wm. Newcomer</u> ADDRESS (Street, city, town, state) <u>Mt. Wilson, Md.</u> DATE SIGNED <u>4/18/60</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>4-20-1960</u>	
NAME OF CEMETERY OR CREMATORY <u>WILKELAND MEMORIAL</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE COUNTY MD.</u>	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <u>Orlino S. Knecht</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY W. JENKINS</u> ADDRESS <u>4405 YORK RD BALTIMORE</u>	
DATE <u>APR 20 '60</u>			

INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



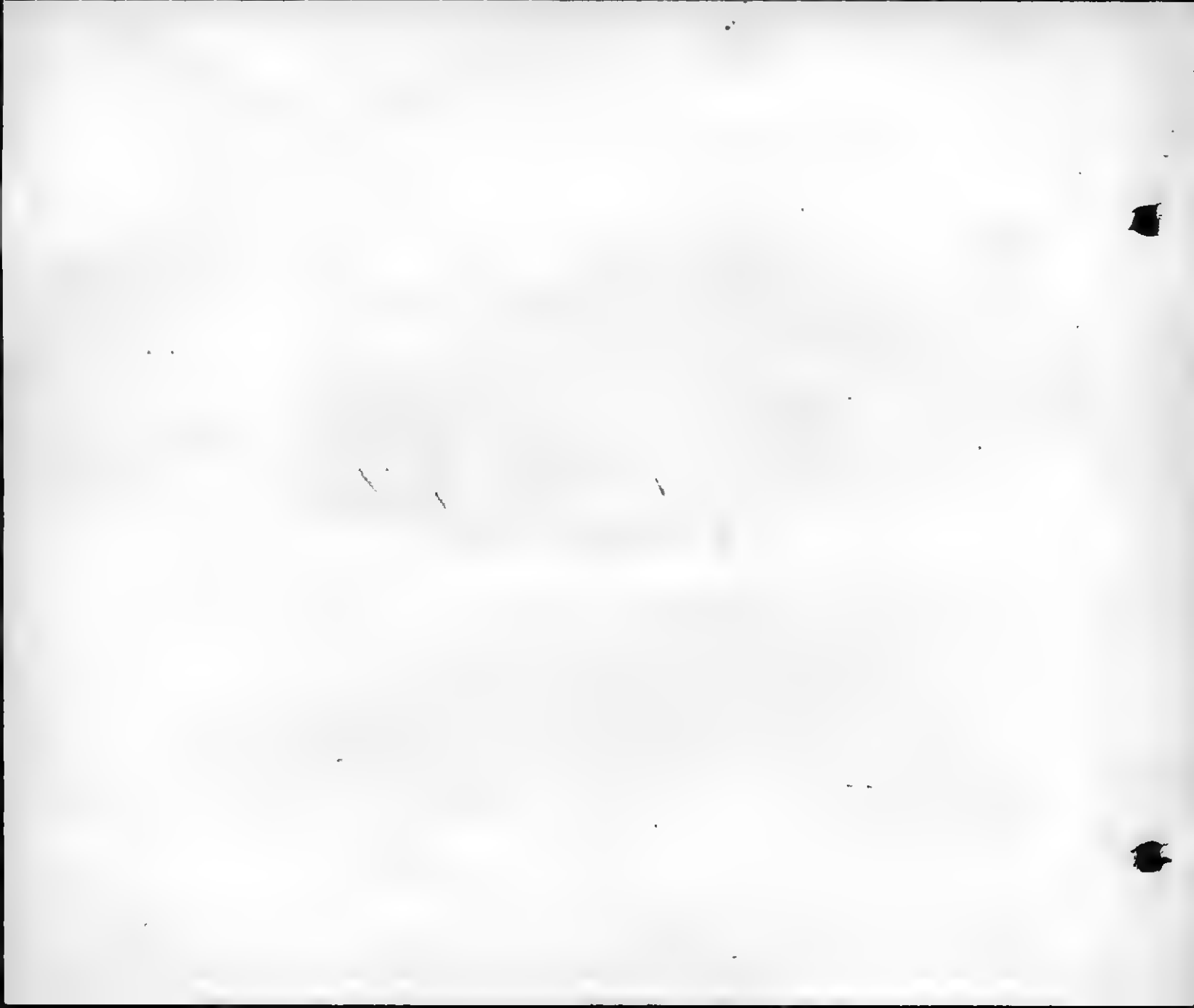


4352

## CERTIFICATE OF DEATH

Reg. Dist. No.

VS A15 (4)  
15M 9/58



may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

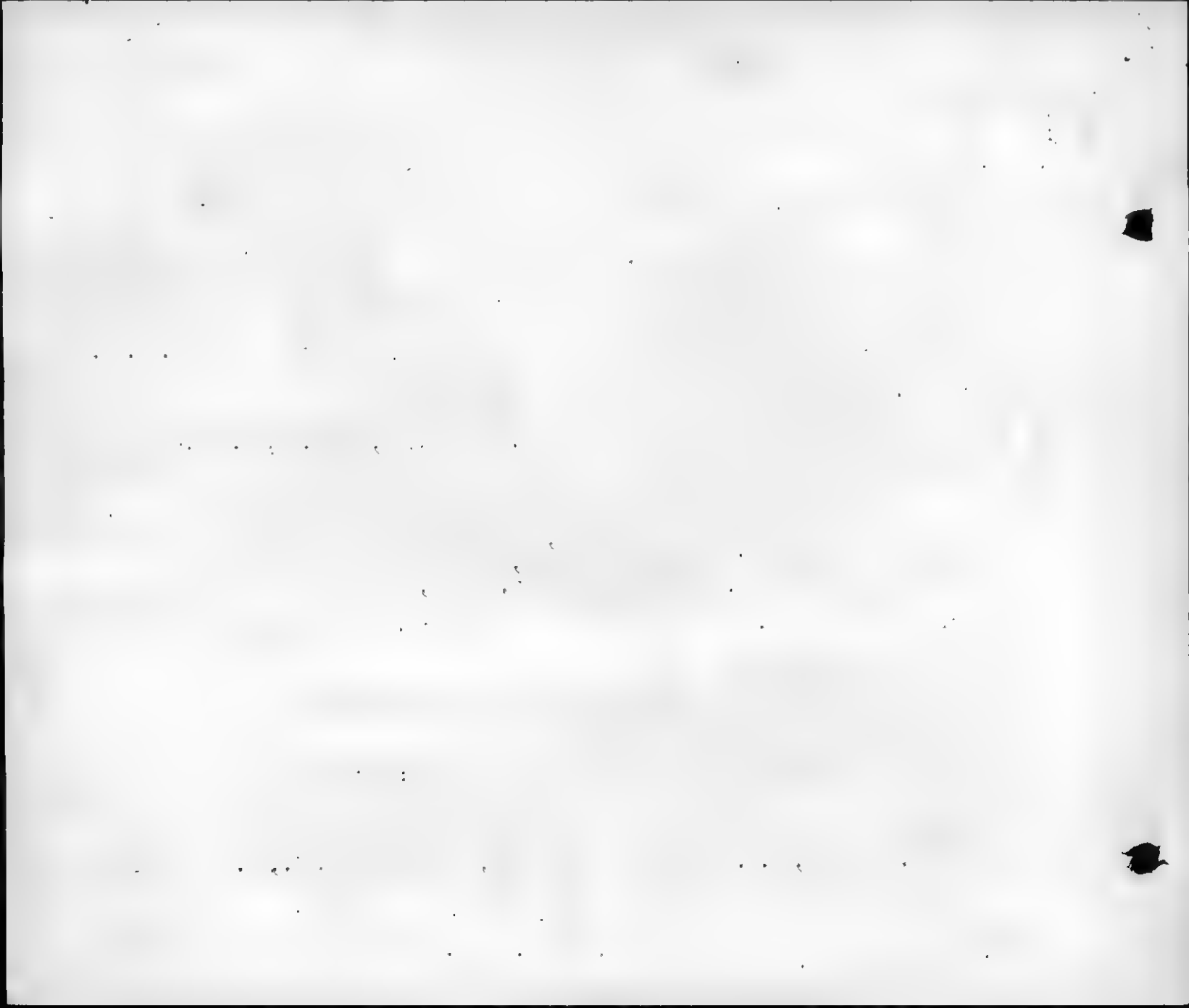
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4358

CERTIFICATE OF DEATH

64306

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>2 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2710 Fleetwood Avenue (14)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES W. TOWERS</b>			4. DATE OF DEATH Month Day Year <b>April 24 19 60</b>				
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>February 28, 1896</b>	9 AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR: Months Days Hours Min. <b>12</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter- retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>		11. BIRTHPLACE (State or foreign country) <b>York, Pennsylvania</b>			
13. FATHER'S NAME <b>Charles H. Towers</b>		14. MOTHER'S MAIDEN NAME <b>Emma Shannon</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>213-12-3812</b>		17. INFORMANT <b>Clin. Recrods, VAH, Balto. 18, Md., Ft. Howard Division</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL FAILURE</b> DUE TO <b>ARTERIOSCLEROTIC AND PULMONARY HEART DISEASE</b> Cauditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PYOGENIC ABSCESS, LEFT KIDNEY</b> (c) <b>CAVERNOUS HEMANGIOMA, LIVER, OLD</b>					INTERVAL BETWEEN ONSET AND DEATH <b>FEW HOURS</b> <b>UNKNOWN</b> <b>RECENT</b>		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Adenomata, adrenals. Benign prostatic hypertrophy. Prostatic calculi</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>			
20f. (City or town) <b>Baltimore</b>		(County) <b>Baltimore</b>		(State) <b>Maryland</b>			
21 I certify that (this hospital) attended the deceased from <b>April 22 1960</b> to <b>April 24 1960</b> , that (I) (we) last saw the deceased alive on <b>April 24 1960</b> , and that death occurred at <b>11:50 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John D. Talbert, M.D.</b>		22b. DATE <b>4/25/60</b>		22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M.D.</b>			
22d. ADDRESS <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. ADDRESS <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>			
23a. BURIAL, CREMATION REMOVAL (Spec. fy) <b>Burial</b>		23b. DATE THEREOF <b>4-28-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore Maryland</b>			
23d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Maryland</b>		23e. REC'D BY REGISTRAR <b>Arthur S. Kline</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc.</b>		ADDRESS <b>6009 Harford Rd., Balto. 14, Md.</b>		DATE <b>APR 27 '60</b>			



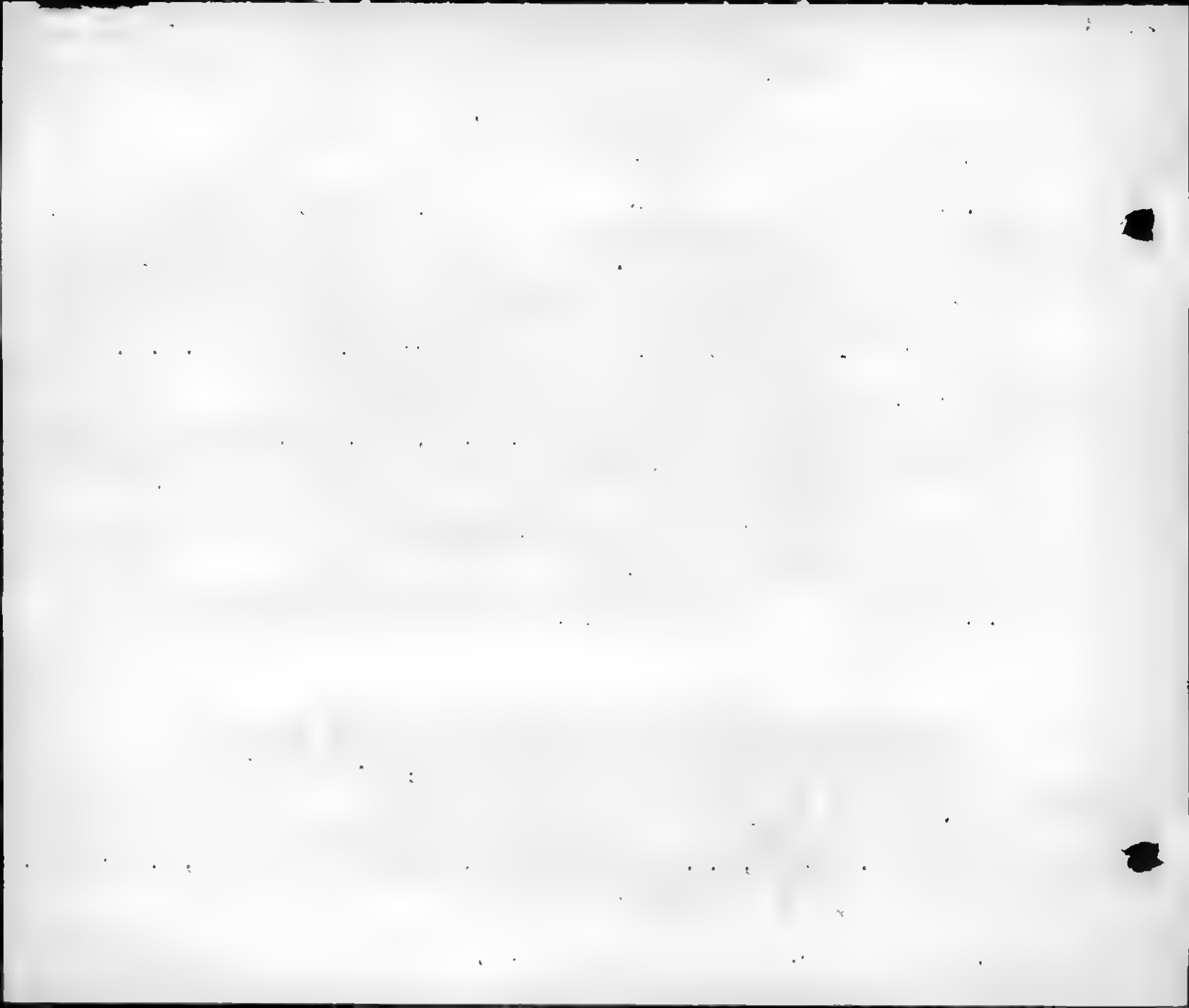
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4360

CERTIFICATE OF DEATH

04308

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>2 Days</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>332 W. Camden Street (1)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>HERBERT G. WELCH</b>				4. DATE OF DEATH Month Day Year <b>April 15 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 7, 1887</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Interior Decorator (unemployed)</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edward R. Welch</b>				14. MOTHER'S MAIDEN NAME <b>Laura Airhardt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW I</b>		16. SOCIAL SECURITY NO <b>217-14-3537</b>		17. INFORMANT Address <b>Clin. Rec. VAH, Balto. 18, Md. Fort Howard Division</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMPHYSEMA</b> <b>527.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) <b>SPLENIC INFARCTS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>RECENT</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Nephrosclerosis, arteriosclerotic. 2. Benign Prostatic Hypertrophy</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.</b>	
20f. (City or town) <b>Baltimore</b>				20g. (County) <b>Baltimore</b>		20h. (State) <b>Maryland</b>	
21. I certify that (1) (this hospital) attended the deceased from <b>April 13, 1960</b> , to <b>April 15, 1960</b> , that (1) (we) lost the deceased alive on <b>April 15, 1960</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Caridad E. Gonzalez</b>				22b. DATE <b>4/15/60</b>		22c. PHYSICIAN'S NAME (Type) <b>CARIDAD E. GONZALEZ, M.D.</b>	
22d. ADDRESS <b>VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22f. ADDRESS <b>VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-19-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem</b>		23d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Blight, Inc. 6009 Harford Road, Balto. 14, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 21 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hirsch</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 64369

## 4234 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> c. LENGTH OF STAY IN 1b <b>49yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Old Hanover Road</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> d. STREET ADDRESS <b>Old Hanover Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) <b>Robert Graham Welsh</b> First Middle Last				<b>4. DATE OF DEATH</b> <b>April 9, 1960</b> Month Day Year						
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Nov. 10, 1910</b>		<b>9. AGE</b> (In years last birthday) <b>49</b> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Florist</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>		
<b>13. FATHER'S NAME</b> <b>Philip B. Welsh</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Charlotte V. Frank</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW 2</b>		<b>16. SOCIAL SECURITY NO.</b> <b>213-01-5585</b>		<b>17. USUAL ADDRESS</b> <b>Robert G. Welsh Jr. Owings Mills, Md.</b>						
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, (b) <b>Coronary Artery Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mental Depression</b>								INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b> <b>2 mos.</b>		
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>none</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>none 19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>none</b>		<b>20f. (City or town)</b> <b>none</b> (County) (State)				
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>										
<b>ACTUAL SIGNATURE</b> <i>D. D. Caples</i> <b>EXAMINER'S NAME (Type)</b> <b>D. D. Caples, M. D.</b>					<b>M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></b> <b>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></b> <b>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></b>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>					<b>22b. DATE THEREOF</b> <b>April 12, 1960</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Bruid Ridge Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> <b>Pikesville, Md.</b> (State)	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>					<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>APR 14 '60</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Hines</i>			

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If only a portion is necessary, please enclose a separate certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

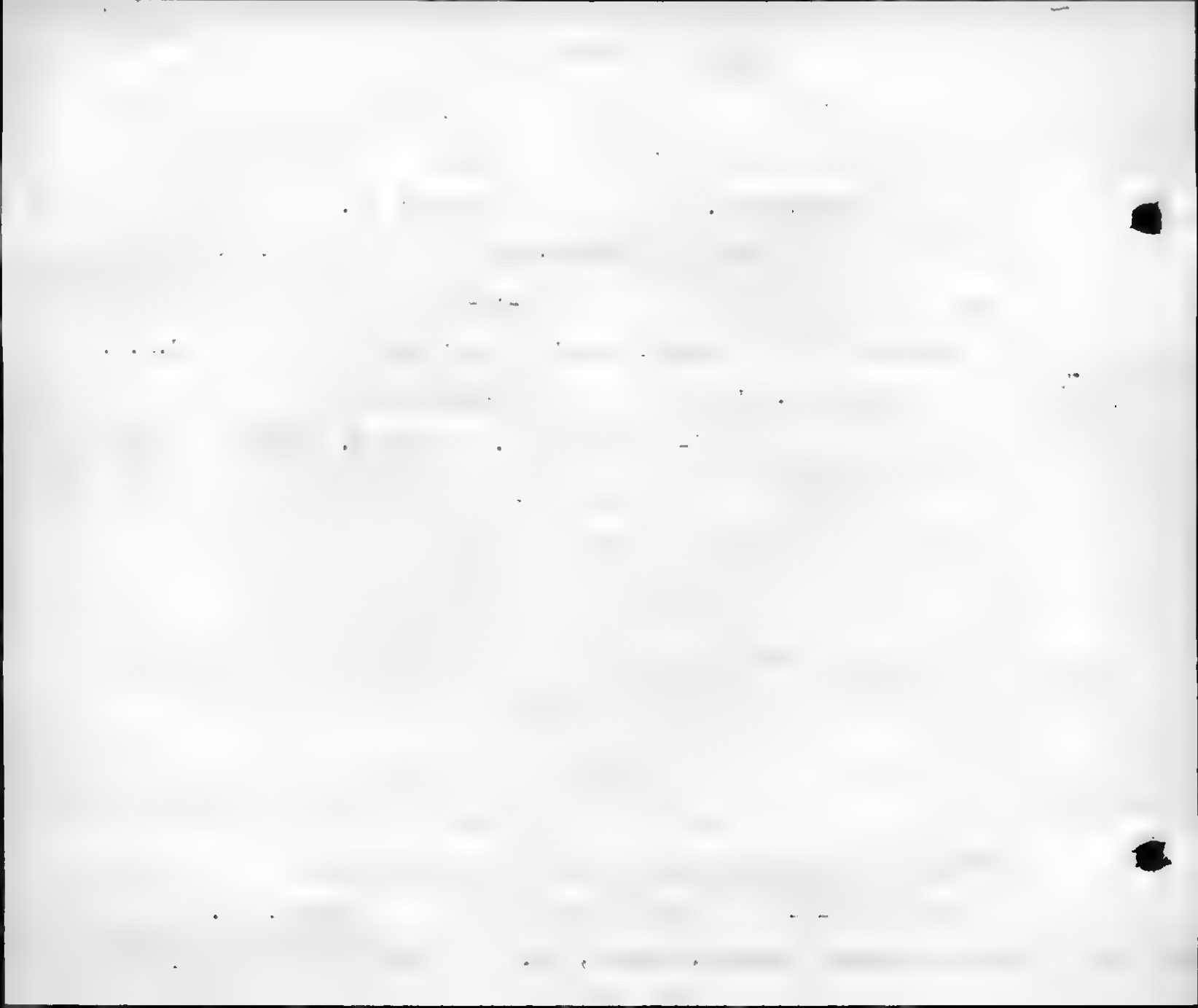
420-1



4361  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Monkton rural</b>		c. LENGTH OF STAY IN lb <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Rd.</b>		e. STREET ADDRESS <b>Carroll Rd.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Webster Wilhelm</b>		4. DATE OF DEATH Month Day Year <b>4-30-60</b> 19	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-12-1891</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>lumber retail</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>M.S.A.</b>	
13. FATHER'S NAME <b>Daniel S. Wilhelm</b>		14. MOTHER'S MAIDEN NAME <b>Tacie Morris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>336-10-2573</b>	
17. INFORMANT <b>Mrs. Richard N. Jones,</b>		Address <b>above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction (acute)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerotic Cardio Vascular Disease</b> DUE TO (c) <b>Diabetes Mellitus</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>5 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1958</b> , 1958, to <b>4-30-</b> 1960, that I last saw the deceased alive on <b>4-30-</b> 1960, and that death occurred at <b>2:20</b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>C. Herbert Mueller Jr. M.D. York Rd., Herford - Parkton P.O. Md. 43060</b>			
ACTUAL SIGNATURE <b>C. HERBERT MUELLER JR.</b>		PHYSICIAN'S NAME (Type) <b>C. HERBERT MUELLER JR. YORK RD., HERFORD, PARKTON P.O. MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-2-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bosley Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>Sparks, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>		24. REC'D BY REGISTRAR DATE <b>MAY 5 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64311

4362 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b> c. LENGTH OF STAY IN 1b <b>16 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head, Maryland</b> d. STREET ADDRESS <b>25 Kenwood Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Jane</b> Last <b>Willet</b>		4. DATE OF DEATH Month <b>4</b> Day <b>18</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/16/38</b>
9. AGE (In years lost birthday) <b>22</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Randall Broyles</b>		14. MOTHER'S MAIDEN NAME <b>Eugenia Willett Dement</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Rosewood Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia due to aspiration of vomitus</b> <b>753.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bilateral bronchopneumonia</b> DUE TO (c) <b>Porencephaly, right</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>2 days</b> <b>Prenatal</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Spastic quadriplegia and symptomatic epilepsy - birth</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11/3/43</b> , 19__ to <b>4/18/60</b> , 19__, that I last saw the deceased alive on <b>4/18/60</b> , 19__, and that death occurred at <b>9:45a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rosewood Training School</b> DATE SIGNED <b>4/26/60</b> ACTUAL SIGNATURE <b>Harry G. Butler</b> M.D. PHYSICIAN'S NAME (Type) <b>Harry G. Butler, M.D.</b> <b>Owings Mills, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 27 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rosewood</b>	22d. LOCATION (City, town, or county) (State) <b>Owings Mills Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline</b> <b>Sms Rustertown Md</b>		24a. REC'D BY REGISTRAR <b>APR 29 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Colleen L. Kinner</b>



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other action is necessary, please enter a note in this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

Item 20 Film 201

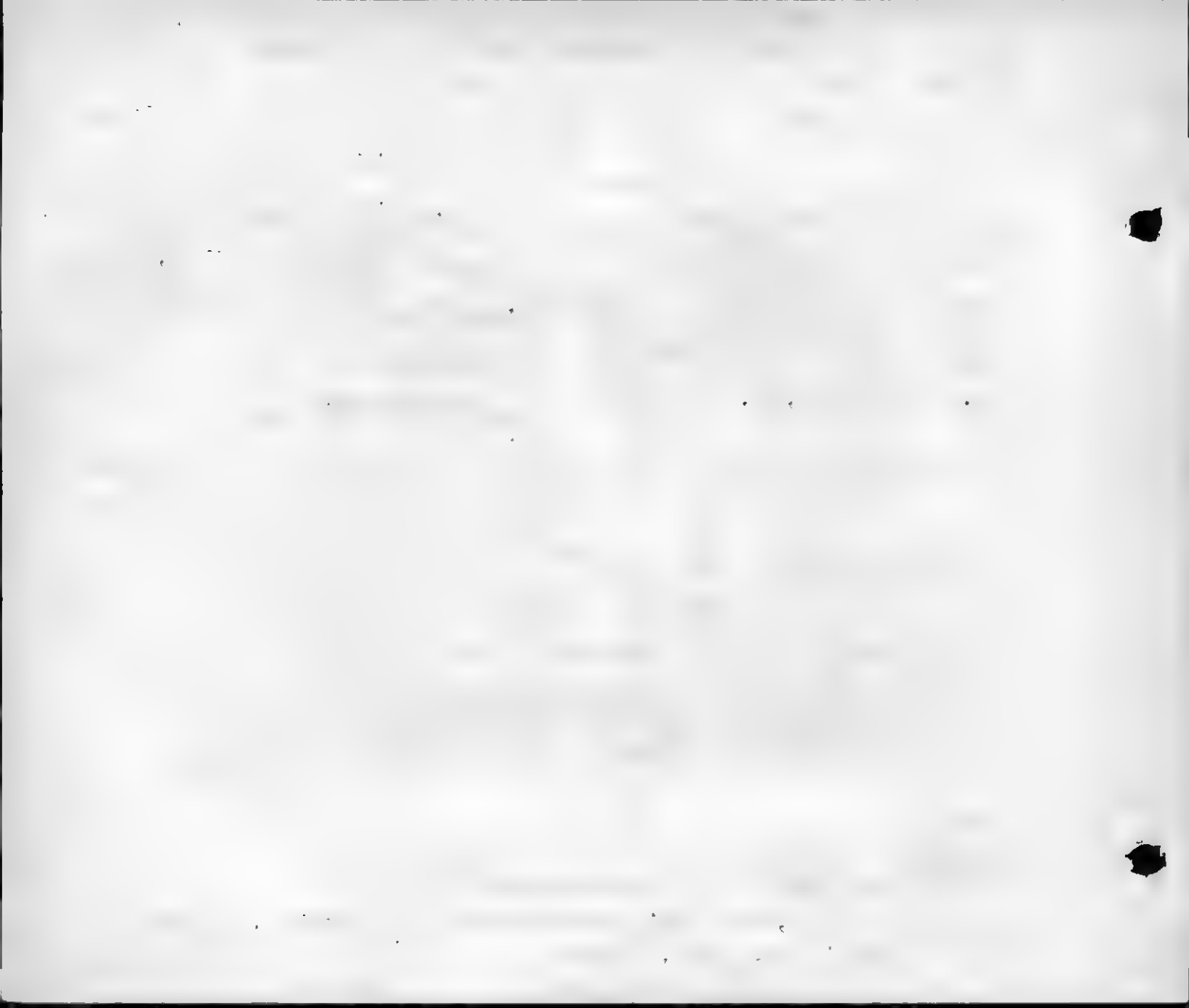
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04312

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1208 Berwick Road</b>		d. STREET ADDRESS <b>704 W. Seminary Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>WENDY SUE WINES</b>		4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 4, 1959</b>
9. AGE (In years last birthday) <b>5</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>1</b> Hours <b>1</b> Min. <b>5</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baby</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>W. Bradford Wines, Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Sue Ellen Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Family Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>925.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>bluff fall</b> DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Infant bled to death from fall of bed caught in corner</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>11</b> o. m. <b>PM</b> <b>4-7-60</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Ruxton Balto. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>[Signature]</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>L. J. Jones</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 9, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE APR 11 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



## 4364 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Sheppard and Enoch Pratt Hospital</u>				d. STREET ADDRESS <u>2660 Woodley Road, N. W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Jane</u> Middle <u>Burke</u> Last <u>Wooden</u>				4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 8, 1873</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wisconsin</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>? Burke</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Hospital Records</u>			
17. INFORMANT <u>Hospital Records</u>				Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO <u>5 yr +</u> (c) <u>5 yr +</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome due to Senile Brain Disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>							
21. I certify that I attended the deceased from <u>Feb 29, 1956</u> , to <u>April 16, 1960</u> , that I last saw the deceased alive on <u>April 14, 1960</u> , and that death occurred at <u>3:35 PM</u> , from the causes and on the date stated above							
ACTUAL SIGNATURE <u>W. W. Elgin</u> M.D. <u>April 16, 1960</u>				ADDRESS (Street, city or town, state) <u>Towson 15, Maryland</u> DATE SIGNED <u>  </u>			
PHYSICIAN'S NAME (Type) <u>W. W. Elgin, M. D.</u>				The Sheppard and Enoch Pratt Hospital			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>				22b. DATE THEREOF <u>April-18-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>	
22d. LOCATION (City, town, or county) <u>Baltimore 2, Md.</u>				(State) <u>  </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart &amp; Mowen Co., 108-W-North-Av. City 1.</u>				24a. REC'D BY REGISTRAR <u>APR 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

422.2



4365

CERTIFICATE OF DEATH

04314

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6018 Old Franklin Rd Baltimore Md</u>		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Calverton</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <u>6018 Old Franklin Rd Baltimore Md</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Grace</u> Last <u>Wychie</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 21 1882</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>22</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>none</u>		14. MOTHER'S MAIDEN NAME <u>none</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Emmit Johnson 6018 Old Franklin Rd Baltimore Md</u>	
17. INFORMANT <u>Emmit Johnson 6018 Old Franklin Rd Baltimore Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>331X</u> DUE TO (c) <u>331X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Cystitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 6 1957</u> to <u>April 13 1960</u> that I last saw the deceased alive on <u>March 19 60</u> and that death occurred at <u>8 a. m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. R. Davidson</u> M.D.		ADDRESS (Street, city or town, state) <u>305A Winters Lane Calverton Md</u> DATE SIGNED <u>4/13/60</u>	
PHYSICIAN'S NAME (Type) <u>Charles Robert Davidson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-16-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>	22d. LOCATION (City, town, or county) (State) <u>Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George D. Nelson 1348 N. Calverton Rd</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 18 60</u>	24b. REGISTRAR'S SIGNATURE <u>Charles R. Davidson</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3-242

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

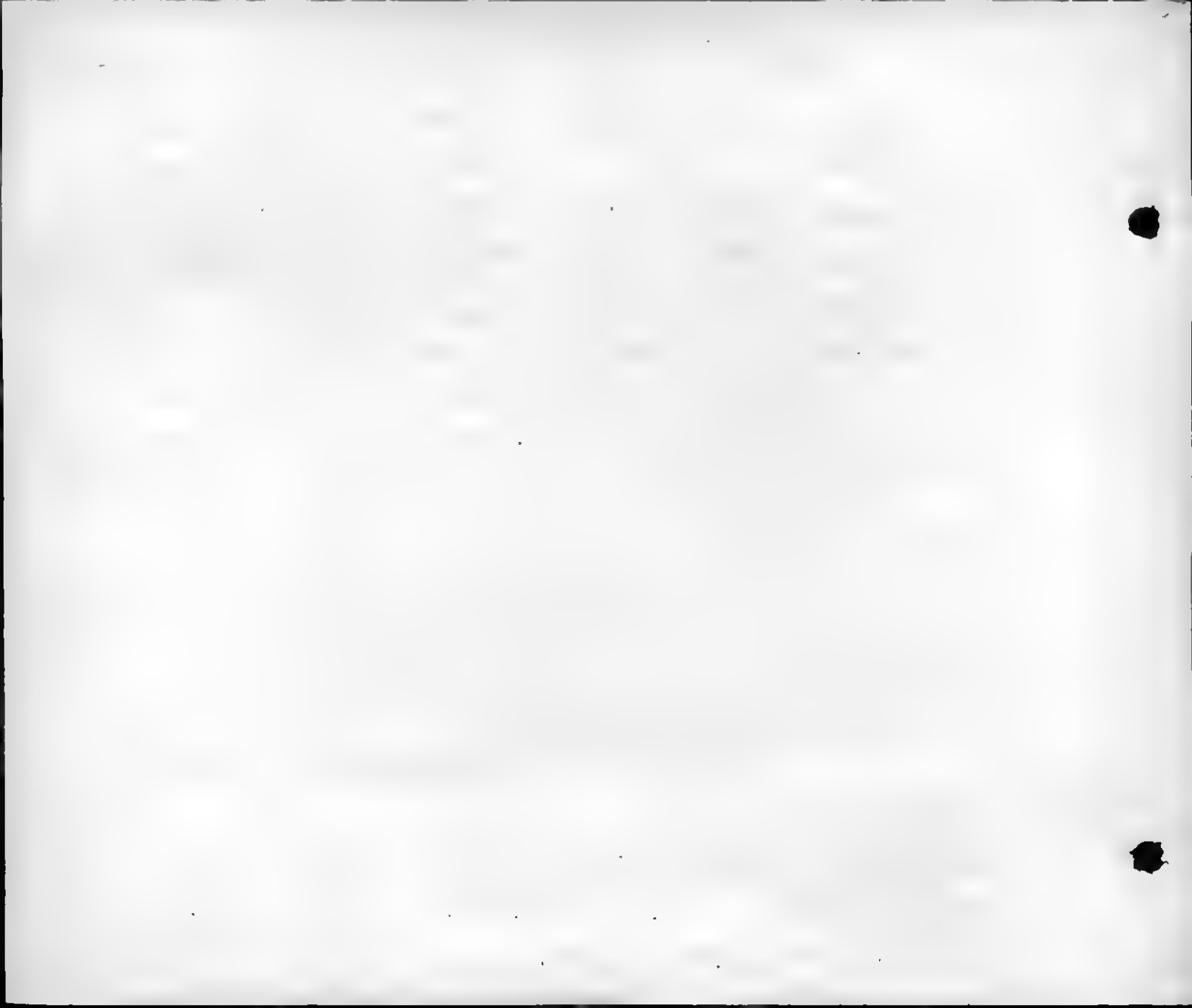
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**4366**

**04315**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2429 Forest Green Rd.</b>				d. STREET ADDRESS <b>2429 Forest Green Rd.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>YETTA YAFFE</b>				4. DATE OF DEATH Month Day Year <b>April 1 19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>78</b> yrs	9. AGE (In years last birthday) <b>78</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Samuel Sherman</b>				14. MOTHER'S MAIDEN NAME <b>Leah ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mrs. Sarah Brager</b>				Address <b>Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senility</b> <b>794X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1959</b> to <b>4/1/60</b> , that (I) (we) last saw the deceased alive on <b>4/1/60</b> and that death occurred at <b>10A</b> M, from the causes and on the date stated above							
22a. SIGNATURE <b>Edward S. Tallins</b>				M D ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/2/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. S. Tallins, M.D.</b>				22d. ADDRESS <b>4300 Liberty N/E Ave</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/3/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Adath Yeshuron Cong.</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Sol Levinson &amp; Bros. Inc.</b>				ADDRESS <b>6010 Reist. Rd.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 5 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4367

## CERTIFICATE OF DEATH

Reg. Dist. No. 4315

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparrows Point</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparrows Point</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2320 Gross Avenue</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Mrs. Alice</i> Middle <i>Young</i> Last <i>Young</i>				4. DATE OF DEATH Month <i>April</i> Day <i>14th</i> Year <i>1960</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec. 8, 1866</i>	
9. AGE (In years last birthday) <i>93</i> yrs.		10. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Carroll Co. Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Henry Miller</i>				14. MOTHER'S MAIDEN NAME <i>?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes, give war or dates of service</i>				16. SOCIAL SECURITY NO. <i>Mr. Harry A. Young, 2320 Gross Avenue.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adeno carcinoma of Breast c</i> <i>170X</i> DUE TO <i>metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>170X</i> DUE TO <i>metastasis</i> (c) <i>metastasis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>6 YR.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized Arteriosclerosis</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 10, 1960</i> to <i>April 14, 1960</i> , that I last saw the deceased alive on <i>April 10, 1960</i> , and that death occurred at <i>8:15 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Charles Allen</i>				ADDRESS (Street, city or town, state) DATE SIGNED <i>Fort Howard, Md. April 4/1960</i>			
PHYSICIAN'S NAME (Type) <i>Dr. Charles Allen</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/18/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Leonard J. Ruck 5305 Harford Road #14</i>				24a. REC'D BY REGISTRAR DATE <i>APR 18 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i>	

X 178

(1)

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

64317

Reg. Dist. No.

4368

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>		c. LENGTH OF STAY IN TB <u>30yrs.</u> X <u>Rural-Parkton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wardon Saw Mill Rd</u>		d. STREET ADDRESS <u>Wardon Saw Mill Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ernest Franz Zierk</u>		4. DATE OF DEATH <u>Apr. 13</u> 19 <u>60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 10, 1876</u> 83 yrs.
9. AGE (in years (say birthday) <u>83</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lithographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lithographing</u>	11. BIRTHPLACE (State or foreign country) <u>Buffalo, N.Y.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Frederick Zierk</u>		14. MOTHER'S MAIDEN NAME <u>Lena ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Wm Barnes</u>		Address <u>Baltimore 18 Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Malnutrition</u> (a), stating the underlying cause last. (c) <u>Malnutrition</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>G. M. France</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/16/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>
		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hartenstein, New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>APR 18 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. France</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1900		St. Paul, Minn.	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Catholic	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
Jan 15, 1945		10:30 AM		St. Paul, Minn.		Dr. J. Smith		St. Paul Hospital	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Death Certifier	
J. Smith		A. Doe		B. Doe		C. Doe		D. Doe	